

EXPANDING PROVIDER BASE FOR SAFE ABORTION IN INDIA: POLICY GAPS

REVISED BASED ON EXPERT GROUP MEETING
ON FEBRUARY 6-7, 2017
IPAS DEVELOPMENT FOUNDATION

ACKNOWLEDGEMENT

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PART A

**WHO Recommendations
and the Indian Context**

Section 1: Background

According to recent statistics, about 11 million abortions¹ are performed in India every year. Unsafe abortions, i.e. those that are carried out by untrained providers and/or at places not suitable for abortions, were found to be responsible for 8% of the maternal deaths in the country way back in 2001-2003². (There is no recent data on the contribution of unsafe abortions to maternal mortality.) This is despite the fact that India legalized abortions through the Medical Termination of Pregnancy (MTP) Act way back in 1971. The lack of access to safe abortion is evident from the data quoted by the national authorities, wherein only about 9 lakh abortions were reported in the national health management information system (HMIS) for the year 2015-16³.

The lack of access to registered facilities, not only because of fewer numbers of the same but also because of their relative clustering in urban and peri-urban areas, is one of the contributory causes to unsafe abortions⁴. The other critical barrier is the lack of trained providers⁵. For example, for provision of overall health care, including but not limited to abortion care services, India has 19 health workers (doctors – 6, nurses & midwives – 13) per 10,000 people. WHO norms recommend 25 providers per 10,000 population. Additionally, there are 7.9 lakh AYUSH practitioners registered in the country (approximately 6.5 per 10,000)⁶.

With the advent of newer and simpler technologies for abortion care, non-physician cadres can now be skilled to carry out some of the tasks (or sub-tasks) within the larger basket of comprehensive abortion care (CAC), thus reducing the reliance on the limited numbers of doctors who are currently the ones permitted to provide the majority of CAC services. This idea of task-shifting and task-sharing for the various CAC related tasks is central to the recent (2015) WHO guidelines on “*Health worker roles in providing safe abortion care and post-abortion contraception*”. These guidelines (henceforth referred to as the “WHO task-shifting guidelines”) form the basis for this background note.

The structure of the background document

This document is divided primarily into 3 parts – Part A (with 3 sections) followed by Parts B and C.

Part A: Section 1 (Background) – It is the current section of the document that provides the background as well as the objectives of the one and a half days’ expert group meeting held on February 06-07, 2017 to discuss the “Role of Health-workers in Expanding Access to Safe Abortion Care and Post-abortion Contraception in India.”

¹ Calculated using the abortion rate for South and central Asia of 37 abortions/ 1000 women 15-44 years old, as given in the journal article – Sedgh G et al. Abortion incidence between 1990 and 2014: global, regional, and sub-regional levels and trends. *The Lancet*. Published online May 11, 2016. [http://dx.doi.org/10.1016/S0140-6736\(16\)30452-4](http://dx.doi.org/10.1016/S0140-6736(16)30452-4)

² SRS 2001-03

³ Health Management Information System (HMIS) report for maternal health. 2015-16. https://nrhm-mis.nic.in/hmisreports/firmstandard_reports.aspx

⁴ Iyengar K et al. Can India transition from informal abortion provision to safe and formal services? *The Lancet* Vol 4, June 2016 (e357-e358). [http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X\(16\)30047-X.pdf](http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(16)30047-X.pdf)

⁵ Health worker roles in providing safe abortion care and post-abortion contraception. World Health Organisation. 2015.

⁶ <http://www.indiamedicaltimes.com/2015/03/13/india-has-9-36-lakh-doctors-of-modern-medicine/>

Part A: Section 2 (Mapping Health worker categories) – This section equates the various cadres of health professionals in India with the cadres described in the WHO task-shifting guidelines, giving reasons for the comparison, in addition to relevant salient points about the cadre in India.

Part A: Section 3 (Mapping recommendations for CAC related tasks and sub-tasks) – This section maps out the recommendations in the WHO task-shifting guidelines regarding the safety, effectiveness, feasibility and acceptability of involving a range of different cadres of health providers to perform abortion related tasks (or sub-tasks), vis-à-vis the situation in India, citing various legal and policy documents to explain the said comparison.

Part B (Recommendations for task-shifting for CAC): This section lists the legal, policy and implementation recommendations that were agreed to by the expert group that will be required in order to ensure that the cadre-wise provision of abortion care in India is as close as possible to the WHO task-shifting guidelines, keeping in mind the feasibility and potential impact (on delivery of CAC services) of that change in the Indian context.

Part C (Self-management of first trimester MMA): This section discusses the applicability of WHO recommendations on self-management (by women) of medical method abortion process in the first trimester in the Indian context. This is a new section, i.e. it was not part of the original version of this background note, and has been added following the discussions at the meeting.

Objectives of meeting

The meeting of experts from India and abroad on February 6-7, 2017 had been called with the following objectives:

1. To review and discuss the first draft of this background paper and validate the assumptions and explanations presented therein, and suggest revisions as and where needed.
2. To review the recommendations for legal, policy and implementation changes, as suggested in the earlier version of this document, and check for their feasibility and potential impact in the Indian context.
3. To suggest steps needed to bring about the agreed upon changes in the Indian context.

The list of experts present at the meeting and the session plan are attached in **Annex 1** and **Annex 2** respectively.

The current version of the document has been revised in view of the discussions at this expert group meeting

Section 2: Mapping health worker categories

This section matches the health worker categories as defined in the WHO task-shifting guidelines with the health worker cadres in India.

It must be noted that the numbers shown as available in the health system are based on the available data source in the public domain. For most of the data on the cadre availability in the public health sector, the Rural Health Statistics (MoHFW) has been referred to as the primary source of information. It must be mentioned here that this data captures only regular / full-time staff in the public sector. Human resource on contractual employment are not included in this data. Thus, this data may be an under-estimation of the cadre numbers available in the public health sector.

WHO Category	1. Specialist doctor					
Description	Postgraduate clinical training and specialization in obstetrics and gynecology.					
INDIA - matching cadre	Obstetrician - Gynecologist					
Matching criteria	The provider may be a degree holder [MD or DNB, both of which are three-year courses after graduation (MBBS)] or a diploma holder (DGO), which is a two-year course after graduation (MBBS).					
Availability	<p>According to the data with the Federation of Obstetrical and Gynecological Societies of India (FOGSI), there are about 29,310 individual FOGSI members (Ob-Gyns) across the country⁷.</p> <p>According to the Rural Health Statistics (RHS) 2015-16⁸, as compared to requirement for existing infrastructure, there was a shortfall of 76.7% for obstetricians & gynecologists in the public health sector facilities.</p>					
		Required (R)	Sanctioned (S)	In-position (P)	Vacant (S-P)	Shortfall (R-P)
	Ob-Gyn at CHCs	5510	3005	1292	1859 (61.90%)	4225 (76.70%)

⁷ <http://www.fogsi.org/fogsi-profile/> (accessed on Feb 02, 2017)

⁸ Rural Health Statistics 2015-16 <https://nrhm-mis.nic.in/Pages/RHS2016.aspx?RootFolder=%2FRURAL%20HEALTH%20STATISTICS%2F%28A%29RHS%20-%202016&FolderCTID=0x01200057278FD1EC909F429B03E86C7A7C3F31&View={3EF44ABD-FC77-4A1F-9195-D34FCD06C7BA}>

WHO Category	2. Non-Specialist doctor												
Description	<ul style="list-style-type: none"> - Medical doctor who holds a university-level degree in basic medical education; - With or without further training in general practice or family medicine; - But NOT in obstetrics and gynecology. 												
INDIA - matching cadre	Doctor – allopathy / MBBS doctor												
Matching criteria	<p>MBBS is a recognized university degree in basic medical education.</p> <p>It is a 4.5 year long course, with an additional 1 year of internship.</p> <p>While obstetrics and gynecology is one of the subjects taught during the course, the MBBS doctors do not carry a specialization in that subject.</p>												
Availability	<p>According to a recent article⁹ on a site that tracks medical news, there were 9,36,488 allopathic doctors registered in India as on 31st December 2014.</p> <p>According to RHS 2015-16⁸, for allopathic doctors at PHCs, there was a shortfall of 12.8% of the total requirement for existing infrastructure as compared to manpower in position.</p> <p>2066 PHCs do not have a doctor.</p>												
	<table border="1"> <thead> <tr> <th></th> <th>Required (R)</th> <th>Sanctioned (S)¹⁰</th> <th>In-position (P)</th> <th>Vacant (S-P)</th> <th>Shortfall (R-P)¹¹</th> </tr> </thead> <tbody> <tr> <td>MBBS doctors at PHCs</td> <td>25354¹²</td> <td>34068</td> <td>26464</td> <td>8774 (25.8%)</td> <td>3244 (12.8%)</td> </tr> </tbody> </table>		Required (R)	Sanctioned (S) ¹⁰	In-position (P)	Vacant (S-P)	Shortfall (R-P) ¹¹	MBBS doctors at PHCs	25354 ¹²	34068	26464	8774 (25.8%)	3244 (12.8%)
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⁹ <http://www.indiamedicaltimes.com/2015/03/13/india-has-9-36-lakh-doctors-of-modern-medicine/>

¹⁰ In some states, the number of sanctioned positions exceeds the “norms” set by RHS for all-India reporting.

¹¹ Does not take into account the numbers from states with a surplus number of personnel compared to the “norms” decided for by RHS for all-India reporting. Therefore, this is the sum of only those states where there was a shortfall.

¹² Calculated @ 1 doctor per PHC

WHO Category	3. Advanced associate and associate clinician
Description	<ul style="list-style-type: none"> - Professional clinician with basic competencies to diagnose and manage common medical and surgical condition; and also - Perform some types of surgery; - Generally requires 3-4 years post-secondary education in a higher institution; - Is registered and his/her practice is regulated by a national / sub-national regulatory authority.
INDIA - matching cadre	No matching cadre in India
Matching criteria	Beyond MBBS and doctors of complementary systems of medicine (AYUSH), there are no other recognized qualifications for clinicians in India.
Availability	Not applicable.

WHO Category	4. Midwife
Description	<ul style="list-style-type: none"> - Trained in the essential competencies of midwifery practice; - Training typically lasts 3 or more years in a midwifery/nursing school; - Leads to a university degree; - Has the full-range of midwifery skills; - Registered with state midwifery or similar regulatory authority.
INDIA - matching cadre	No matching cadre in India
Matching criteria	<p>There is no dedicated course for midwifery recognized in India.</p> <p>None of the present nursing courses provide training in the full range of midwifery skills as defined in the International Confederation of Midwives (ICM) guidelines on competencies for basic midwifery practice¹³.</p>
Availability	Not applicable.

¹³ ICM Essential Competencies for Basic Midwifery practice (2010, amended in 2013)
<http://www.internationalmidwives.org/what-we-do/education-core-documents/essential-competencies-basic-midwifery-practice/>

WHO Category	5. Nurse												
Description	<ul style="list-style-type: none"> - Education includes 3 or more years in nursing school; - Leads to a university or postgraduate university degree; - Registered to practice after examination by a state board of nurse examiners or similar regulatory authority. 												
INDIA - matching cadre	Nurse												
Matching criteria	<p>There are two kinds of recognized basic nursing courses in India¹⁴.</p> <ul style="list-style-type: none"> - The GNM course is <ul style="list-style-type: none"> * A 3-year diploma course, followed by a 6-month internship. * Examination is undertaken by the nursing examination board * Registered by the Indian Nursing Council (INC) as “Registered Nurse and registered midwife” (RN & RM) - The B.Sc. (Basic) Nursing course is <ul style="list-style-type: none"> * A 4-year course * Examination is undertaken by a University * Registered by the Indian Nursing Council (INC) as “Registered Nurse and registered midwife (RN & RM) 												
Availability	<p>As on 31st December 2014, there were 17,91,285 RN & RMs in the country¹⁵.</p> <p>As on 31st March 2016¹⁵, there were</p> <ul style="list-style-type: none"> * 3040 nursing institutions offering GNM course, with a total of 1,22,017 seats. * 1752 nursing institutions offering B.Sc. Nursing course, with a total of 88,211 seats. <p>This reflects the significant potential to increase the availability of “eligible” health providers for CAC services by shifting some tasks/sub-tasks to the nurses.</p> <p>According to RHS 2015-16⁸, the status of nursing personnel in public sector facilities is as shown below.</p>												
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¹⁴ <http://www.indiannursingcouncil.org/nursing-programs.asp?show=prog-type>

¹⁵ Indian Nursing Council Annual Report 2015-16

http://www.indiannursingcouncil.org/pdf/annual_report_2015_16.pdf

¹⁶ Calculated @ 1 nurse per PHC and 7 nurses per CHC

WHO Category	7. Doctor of complementary systems of medicine
Description	<ul style="list-style-type: none"> - A professional of traditional and complementary systems of medicine (non-allopathic physician); - Training includes a 4-5 year University degree; - Includes teaching of <ul style="list-style-type: none"> * human anatomy, * physiology, * management of normal labor, and * pharmacology of modern medicines used in obstetrics and gynecology, in addition to their systems of medicine.
INDIA - matching cadre	AYUSH provider (including BAMS, BHMS, BUMS and BSMS)
Matching criteria	<p>All the 3 courses – BAMS, BHMS and BUMS – are 4.5 year university degree courses followed by a year-long internship.</p> <p>The registration of the providers is managed by</p> <ul style="list-style-type: none"> * The Central Council of Indian Medicine (CCIM) * The Central Council of Homeopathic Medicine (CCHM) <p>A review of the <u>BAMS (Ayurveda)</u> syllabus¹⁹ reveals that the following topics are covered.</p> <ul style="list-style-type: none"> * Anatomy, including that of the female reproductive system; * Physiology, including that of the female reproductive system; * Obstetrics (called “<i>prasuti tantra</i>”) - a subject in the 3rd year; * Management of normal labor and common obstetric complications; * Surgical procedures, indications and contraindications for various interventions including dilatation and curettage (D&C) and female surgical sterilization; observation/assistance in procedures like D&C and D&E; * In the second year, they are also trained on the basic pharmacology of allopathic drugs, including “pharmaco-therapeutics of allopathic drugs in obstetrics and gynecology” in addition to the Ayurveda system of medicine. <p>Both anatomy and physiology are taught using Ayurveda concepts as well as the “modern” medicine (allopathy) concepts.</p> <p>A review of the <u>BHMS (Homeopathy)</u> syllabus²⁰ reveals that the following topics are covered</p> <ul style="list-style-type: none"> * Applied anatomy and applied physiology included as part of the curriculum of obstetrics; * Management of normal labor and common obstetric complications, including abortions;

¹⁹ <https://www.ccimindia.org/ayurveda-syllabus.php>

²⁰ <http://www.similibis.com/syllabus/>

- * Inter-relationship of different schools of pharmacy with emphasis on relationship of Allopathic and Homoeopathic Pharmacy. HOWEVER, “modern” (allopathic) medicine does not appear to be covered specifically in the course.

A review of the BUMS (Unani) syllabus²¹ reveals that the following topics are covered

- * Anatomy, including that of the female reproductive system;
- * Physiology, including that of the female reproductive system;
- * Obstetrics (and care of newborn) - a distinct subject in the final year;
- * Management of normal labor as well as common obstetric complications;
- * Abortion, including D&C as a surgical procedure;
- * In the second year, also trained on the basic pharmacology of allopathic drugs, including “hormones” and “contraceptives” etc. in addition to the Ayurveda system of medicine.

A review of the BSMS (Siddha) syllabus²² reveals that the following topics are covered

- * Anatomy including that of the female reproductive system;
- * Physiology, including that of the female reproductive system;
- * Management of normal labor as well as common obstetric complications;
- * Management of abortion (spontaneous);
- * Obstetrics is a distinct subject on which there is a separate paper in the final year;
- * HOWEVER, they are not taught the pharmacology of any of the “modern” (allopathic) medicines.

The recommended text books for many subjects including anatomy, physiology and even obstetrics include books that are used for allopathic (MBBS) courses.

Availability

As on 1st January 2013, number of providers registered to practice these indigenous systems of medicine include²³

- * BAMS 3,87,976;
- * BHMS 2,38,648;
- * BUMS 50,475;
- * BSMS 7600;
- * TOTAL 6,84,699

According to RHS 2015-16⁸, of the 25,354 PHCs functioning in the country on 31st March, 2016, 10,279 (40.5%) had AYUSH facilities.

²¹ <https://www.ccimindia.org/unani-syllabus-curriculum.php>

²² <https://www.ccimindia.org/siddha-syllabus.php>

²³ Human Resources in the Health sector. National Health Profile 2013. SEARO, World Health Organisation. http://www.searo.who.int/entity/human_resources/data/india-2013.pdf

WHO Category	8. Pharmacist												
Description	<ul style="list-style-type: none"> - A health practitioner who dispenses medicines; - Can counsel on the proper use and adverse effects of drugs and medicines following prescriptions issued by medical doctors / health professionals; - Education includes university level training in theoretical and practical pharmacy, pharmaceutical chemistry or related field. 												
INDIA - matching cadre	Pharmacist												
Matching criteria	<p>B. Pharm is a 4 year degree course for those entering after completing their 10+2 education, and 3 years for those with “lateral entry” i.e. those students who have completed a D.Pharm (diploma) course.²⁴</p> <p>The experts shared that in terms of licensing requirements for opening and running a pharmacy / chemist shop, both degree and diploma holders in pharmacy are treated at par with each other. Hence no differentiation between these two qualifications has been made in this document either.</p> <p>Registered under the Pharmacy Council of India.</p> <p>As per the syllabus prescribed by the Pharmacy Council of India, “Communication Skills” are covered in the first semester itself.</p>												
Availability	<p>As on 1st January 2014, the number of registered pharmacists in India was 6,43,301²³.</p> <p>According to RHS 2015-16⁸, the status of pharmacists in public sector facilities was as shown below.</p> <table border="1"> <thead> <tr> <th></th> <th>Required (R)</th> <th>Sanctioned (S)</th> <th>In-position (P)</th> <th>Vacant (S-P)</th> <th>Shortfall (R-P)</th> </tr> </thead> <tbody> <tr> <td>Pharmacists at PHCs and CHCs</td> <td>30864²⁵</td> <td>30138</td> <td>25654</td> <td>4884 (16.2%)</td> <td>6969 (22.6%)</td> </tr> </tbody> </table>		Required (R)	Sanctioned (S)	In-position (P)	Vacant (S-P)	Shortfall (R-P)	Pharmacists at PHCs and CHCs	30864 ²⁵	30138	25654	4884 (16.2%)	6969 (22.6%)
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²⁴ http://iul.ac.in/DepartmentalData/Pharmacy/B.%20Pharm%20PCI_syll%202016.pdf

²⁵ Calculated @ 1 each per PHC and CHC

WHO Category	9. Pharmacy worker
Description	<ul style="list-style-type: none"> - Technicians or assistants who perform various tasks associated with dispensing medicinal products; - Works under the guidance of a pharmacist; - Pharmacy technicians' training typically is 2-3 years in a pharmaceutical school; - Awarded not equivalent to a university degree; - Pharmacy assistants have 2-3 years of secondary school; - Followed by a period of on-the-job training or apprenticeship.
INDIA - matching cadre	Pharmacy worker
Matching criteria	<p>There is no exact match for this category; persons with a variety of qualifications and tasks allocations work at pharmacies and support the pharmacist.</p> <p>However, for the purpose of this document, those who are involved in assisting the pharmacists in dispensing medicines have been assumed to fit the role of the pharmacy worker. The expert group added that, for the sake of this document, it is assumed that these are those workers who do not have any standard qualification and registration that is required under the Drugs and Cosmetics Act to dispense medicines and/or provide information (related to the drugs and medication).</p>
Availability	None.





WHO Category	10. Lay health worker
Description	<ul style="list-style-type: none"> - Performs functions related to health care delivery or information provision - Trained in some way in the context of the task - BUT has not received any professional or paraprofessional certificate or tertiary education degree.
INDIA - matching cadre	Accredited Social Health Activist (ASHA)
Matching criteria	<p>In the ASHA training manuals, her overall role is defined as three-fold:</p> <ul style="list-style-type: none"> * to be a facilitator of health services and link people to health care facilities, * to be a provider of community level health care, and * to be an activist, who builds people’s understanding of health rights and enables them to access their entitlements. <p>Capacity building of ASHA is being seen as a continuous process. ASHA undergoes a series of modular training (presently there are 7 modules) to acquire the necessary knowledge, skills and confidence for performing her spelled out role.</p> <p>With reference to abortion care, the ASHA training modules not only have a complete chapter on “Safe abortion” in module 2, 3 and 7, but discuss abortion related issues wherever relevant in other sections too. Some of the focus areas include:</p> <ul style="list-style-type: none"> - The social context of abortion (why women seek abortion) - The legal context for abortion services in India (provision of the MTP Act and the PC&PNDT ACT). - The methods that can be used for provision of abortion (surgical and medical) - Post-abortion care, including danger signs to watch out for - The facility where a woman can seek abortion services such as the PHC, CHC and district hospital, with information about where to go for referral care if needed. - Post-abortion contraception - ASHA’s role in providing safe abortion care <ul style="list-style-type: none"> * Counseling / providing information to the woman about when and where to seek safe abortion services * Visiting the woman after she has had an abortion * Informing the woman about danger signs to watch out for following abortion * Motivating the woman for post-abortion contraception. - <p>According to the GOI guidelines, she should be literate, with preference given to those who have completed 10th grade²⁶.</p>

²⁶ About Accredited Social Health Activist (ASHA) <http://nrhm.gov.in/communitisation/asha/about-asha.html>

Section 3: Mapping recommendations for CAC related tasks and sub-tasks

How to read the mapping below

1. The WHO task-shifting guidelines categorise recommendations for the various health provider cadres to perform the different CAC related tasks and sub-tasks into 4 categories. While the previous version of the background document changed the terminology for the WHO recommendations to 'match' the one used to define the status in India, it has now been revised back to the original WHO terminology to ensure there is no misinterpretation of the WHO data. The following is the classification of recommendations in the WHO task-shifting guidelines which has been replicated in this revised version of the background document.

WHO recommendation category	Symbol used by WHO	Explanation	Interpretation for 'matching' with Indian scenario
Recommended		- Benefits outweigh potential harms - Can be implemented at scale.	Permitted under all circumstances
Recommended in specific circumstances		- Benefits outweigh potential harms under specific circumstances - Can be implemented under these specific circumstances.	Conditionally permitted, with the condition/specific circumstances detailed in the footnote
Recommended in the context of rigorous research		- Important uncertainties about this option - Rigorous research needed to address these uncertainties.	Not permitted (under the current circumstances)
Recommended against		- Option should not be implemented.	Not permitted

2. For the specifying status in India various phrases have been used.

Status in India	Explanation
Permitted	Unconditionally / fully permitted
Partially permitted	Where some of the technical elements of the overall task are permitted but not the complete task
Conditionally permitted	Where the provider needs to fulfil some legal or policy conditions to be able to perform the task
Not permitted	Self-explanatory
Do not know	Where none of the CAC related policy and training documents give any information regarding that particular task for a specific cadre









3. The matching (or lack of it) is reflected in terms of colours

Colour	Interpretation
Greyed out text	WHO does not recommend the cadre to perform the task / sub-task
Green	Status in India matches the WHO recommendation, so no action required
Yellow	Status in India - cadre partially / conditionally permitted to perform task recommended (either at scale or under specific circumstances) by WHO.
Orange-red	Status in India - cadre not permitted to perform task recommended (either at scale or under specific circumstances) by WHO.

4. Wherever there is a difference in the WHO recommendation and the status in India (the yellow and the orange-red), and explanation has been given which cites various legal and policy documents to provide documentary back-up to the matching.
5. As part of this explanation of the gaps, some cadres have been clubbed together. It needs to be clarified that the clubbing of cadres is not meant to imply equivalence of the different cadres, (such as AYUSH providers and nurses), but rather the equivalence of the “issues” that is resulting in the matching gap.
6. While the WHO says that it “assumes that the assigned health workers will receive task-specific training prior to implementation”, the experts said that any additional training requirements for any health worker cadre beyond the qualification / pre-service training which is mandated under the law to allow the cadre to perform certain CAC related tasks/sub-tasks should be listed as a “conditionality” and be mentioned as such in the document.
7. In the first version of this background document that was discussed by the Expert Group in the meeting held in Feb 2017, there were also some special questions related to the mapping section for the group to discuss. The group’s responses to those questions have been merged in the mapping section that follows.

Task 1: Management of abortion and Post-abortion Care in the FIRST TRIMESTER

Task 1.1: Vacuum aspiration for induced abortion

<i>WHO description of task:</i> This includes								
<ul style="list-style-type: none"> - Assessment of gestational age (will need skills to perform a bimanual pelvic examination to diagnose and date a pregnancy); - The actual procedure of vacuum aspiration (will need skills to perform a trans-cervical procedure); - Pain management, including the provision of a paracervical block, if needed; and - Assessment of completeness of abortion through visual inspection of products 								
	ASHA	Pharmacy worker	Pharmacist	AYUSH doctor	ANM	Nurse	MBBS doctor	Ob-Gyn
WHO				 27	 28			
India	Not permitted	Not permitted	Not permitted	Not permitted	Not Permitted	Not Permitted	Conditionally permitted	Permitted

Gap # 1.1.1 – AYUSH doctors and Nurses not permitted to provide VA for first trimester abortions

Cadre: AYUSH doctor, Nurse, ANMs

Explanation:

- MTP Act allows only Registered Medical Practitioners (RMPs), as defined under the Indian Medical Council Act 1956, to terminate pregnancy.
- The Indian Medical Council Act, 1956 captures only MBBS and other allopathic specializations under its registered schedules.
 - None of the AYUSH qualifications are recognized under this Act and hence they are not defined as RMPs.
 - The nursing personnel, like GNMs, those with a B.Sc. Nursing degree and ANMs, are also not recognized as RMPs.
- With reference to the “conditionality” in the WHO task-shifting guidelines about the specific circumstances under which it recommends ANMs perform vacuum aspiration (i.e. if they are already involved in BEmOC and/or PAC)
 - In India while ANMs are recognized as Skilled Birth Attendants, they are not permitted to perform all the signal functions of BEmOC - most notably manual removal of placenta, assisted vaginal delivery and removal of retained products of conception (except digital removal when products are visible at the cervical os); even for other functions such as administration of antibiotics, uterotonics and anti-convulsants, they are allowed to give only the first pre-referral dose.
 - There is no specific role defined for ANMs in post-abortion care

²⁷ Where health systems have mechanisms that allow participation of doctors of complementary systems of medicine in other tasks related to reproductive and maternal health care.

²⁸ Where ANMs already engaged in BEmOC or Post-abortion Care (PAC)









Gap # 1.1.2 – Restrictions on MBBS doctors for providing VA for first trimester abortions

Cadre: MBBS doctor

Explanation:

- The permission is “conditional” because, according to the Operational guidelines for CAC services²⁹, (page 4), it varies with level of facility
 - In the public sector - at the PHC/Level 2 facility, the MBBS doctor is permitted to conduct VA up to 8 completed weeks only;
 - In the public sector - at level 3 facilities, the MBBS doctor is permitted to conduct VA for the complete first trimester (up to 12 weeks);
 - In the approved private sector facilities, the MBBS doctor is permitted to conduct VA for the complete first trimester (up to 12 weeks).
- The permission is “conditional” also because, according to the MTP Act (including its Rules and Regulations) as well as the various policy guidelines including the Operational guidelines for CAC services, 2012²⁹ (pages 4 & 5), the permission is for CAC trained doctors only. These MBBS doctors need to fulfil at least one of the three criteria
 - Completed six months as house surgeon in Obstetrics and Gynaecology
 - Has at least one year experience in the practice of Obstetrics and Gynaecology at any hospital that has all facilities
 - Assisted an RMP in 25 cases of medical termination of pregnancy of which at least five have been performed independently in a hospital established or maintained by the government or a training institute approved for this purpose by the government.

²⁹ Comprehensive Abortion Care Operational Guidelines. Ministry of Health and Family Welfare, Government of India, April 2014. http://nrhm.gov.in/images/pdf/programmes/maternal-health/guidelines/CAC_Operational_guidelines.pdf

Task 1.2: Vacuum aspiration for management of incomplete abortion								
<p><i>WHO description of task:</i> This includes</p> <ul style="list-style-type: none"> - Recognizing the condition; - Assessing uterine size; - The actual evacuation procedure; and - Pain management. <p>[Incomplete abortion can occur after an induced or spontaneous abortion (i.e. miscarriage). The management is identical and the WHO recommendations apply to both situations.]</p>								
	ASHA	Pharmacy worker	Pharmacist	AYUSH doctor	ANM	Nurse	MBBS doctor	Ob-Gyn
WHO				 27	 30			
India	Not permitted	Not permitted	Not permitted	Absence of guidelines	Not Permitted	Not Permitted	Partially Permitted	Partially Permitted

Gap # 1.2.1 – AYUSH doctors and nurses not permitted to provide VA to manage first trimester incomplete abortions.

Cadre: AYUSH doctor, Nurse, ANMs

Explanation:

- The management of incomplete abortion is not subject to the MTP Act (including its Rules and Regulations).
- The Operational Guidelines for CAC²⁹ services (Page 5) specify that Nurses and ANMs are not permitted to perform evacuation for management of incomplete abortions.
- None of the CAC related policy and training documents make any reference to AYUSH providers. As they have been awarded special permissions, through government orders, to perform other RMH related activities (like provision of delivery care), the absence of any such order for CAC related services including for management of incomplete abortion, is presumed to be a “not-permitted” status for this cadre.
- With reference to the “conditionality” in the WHO task-shifting guidelines about the specific circumstances under which it recommends ANMs perform vacuum aspiration (i.e. if they are already involved in BEmOC)
 - In India while ANMs are recognized as Skilled Birth Attendants, they are not permitted to perform all the signal functions of BEmOC - most notably manual removal of placenta, assisted vaginal delivery and removal of retained products of conception (except digital removal when products are visible at the cervical os); even for other functions such as administration of antibiotics, uterotonics and anti-convulsants, they are allowed to give only the first pre-referral dose.

³⁰ Where ANMs already engaged in BEmOC and where referral and monitoring systems are strong.

Gap # 1.2.2 – Gestational age and other restrictions on MBBS doctors for providing VA to manage first trimester incomplete abortions.

Cadre: MBBS doctor, Ob-Gyn

Explanation:

- The management of incomplete abortion is not subject to the MTP Act (including its Rules and Regulations).
- The permission is “partial” because, the Provider’s Manual³¹ for CAC (page 98), limits the use of VA for incomplete abortion till 12 weeks only. In fact, it categorically states that VA is contraindicated for management of incomplete abortions when the uterine size exceeds 12 weeks. This is a week less than the 13 weeks recommended by WHO.
- According to the Operational guidelines for CAC services²⁹, (page 4), in the public sector - at the PHC/Level 2 facility, the MBBS doctor is permitted to conduct VA for MTP and incomplete (and inevitable) abortions. While the gestational age for MTP is limited up to 8 completed weeks only at this facility level, no such limits are defined for management of incomplete and inevitable abortions.
- In practice, medical officers at PHCs do not offer VA services for incomplete abortions too beyond 8 weeks of gestation. Field experience³² shows that this is because medical officers are under the misconception that the policy restriction on provision of MTP services at PHCs using VA for gestations beyond 8 weeks is applicable for management of incomplete abortions too.

³¹ Comprehensive Abortion Care Provider’s Manual. Ministry of Health and Family Welfare, Government of India. April 2014. http://nrhm.gov.in/images/pdf/programmes/maternal-health/guidelines/CAC_Providers_Manual.pdf

³² Ipsas Development Foundation’s field experience

Task 1.3: Medical abortion with mifepristone + misoprostol								
Sub-task 1.3.1: Assessment of eligibility								
WHO description of task: This includes <ul style="list-style-type: none"> - Diagnosing and dating the pregnancy; - Ruling out contraindications; and - Screening for possible ectopic pregnancy. 								
	ASHA	Pharmacy worker	Pharmacist	AYUSH doctor	ANM	Nurse	MBBS doctor	Ob-Gyn
WHO								
India	Not permitted	Not permitted	Not permitted	Not permitted	Not Permitted	Not Permitted	Permitted	Permitted
Sub-task 1.3.2: Administration of medications and management of the process								
WHO description of task: This includes <ul style="list-style-type: none"> - Administration of medications with instructions on their appropriate use; and - Managing the common side effects. (It is not essential that person providing medical abortion should also be trained and competent in vacuum aspiration. However, in such cases, back-up referral to a provider who can perform VA, if needed, should be ensured)								
	ASHA	Pharmacy worker	Pharmacist	AYUSH doctor	ANM	Nurse	MBBS doctor	Ob-Gyn
WHO								
India	Not permitted	Not permitted	Not permitted	Not permitted	Not permitted	Not permitted	Partially conditionally permitted	Partially conditionally permitted
Sub-task 1.3.3: Assessment of abortion completeness								
WHO description of task: This includes <ul style="list-style-type: none"> - Assessing that the abortion process is complete and that no further intervention is required. 								
	ASHA	Pharmacy worker	Pharmacist	AYUSH doctor	ANM	Nurse	MBBS doctor	Ob-Gyn
WHO								
India	Not permitted	Not permitted	Not permitted	Not Permitted	Not permitted	Not permitted	Permitted	Permitted

Gap # 1.3.1 – AYUSH doctors, Nurses and ANMs not permitted to provide first trimester abortions using medical methods.

Cadre: AYUSH doctor, ANM, Nurse

Explanation:

³³ Up to 10 weeks of gestation only

- MTP Act allows only Registered Medical Practitioners (RMPs), as defined under the Indian Medical Council Act 1956, to terminate pregnancy.
- The Indian Medical Council Act, 1956 captures only MBBS and other allopathic specializations under its registered schedules.
 - None of the AYUSH qualifications are recognized under this Act and hence they are not defined as RMPs.
 - The nursing personnel, whether GNM, B.Sc Nursing or ANM are also not recognized as RMPs.
- The CAC Provider Manual³¹ as well as the Handbook on Medical Methods of Abortion³⁴ list all the different sub-tasks (including assessing the eligibility of the woman for MMA and assessing the completeness of abortion following administration of the drugs) as part of the complete process. It does not list separate cadres for the sub-tasks. Hence, providers who are not permitted to perform MMA are deemed to be not eligible to perform the whole procedure, including any of the sub-tasks as defined in the WHO task-shifting guidelines.

Gap # 1.3.2 – Gestational age and other restrictions on MBBS doctors for providing first trimester abortions using medical methods

Cadre: MBBS doctor, Ob-Gyn

Explanation:

- The permission for MMA is categorized as “conditional” because, according to the MTP Act, while an MBBS doctor (including both non-specialists as well as Ob-Gyn specialists) are permitted to perform MTP using the medical methods at her/his clinic, the clinic should be
 - Either an “approved” site for MTP as defined under section 4 of the MTP Act (read with Rule 5 of the MTP Rules)
 - Or have “access” to such an approved site. For the purpose of access, the RMP should display a certificate to this effect from the owner of the approved place.
- The permission is “conditional” for MBBS (non-specialist) doctors also because, according to the MTP Act as well as the various policy guidelines including the Operational guidelines for CAC services, 2012 (pages 4 & 5)²⁹, the permission is for CAC trained doctors only. These MBBS doctors need to fulfil at least one of the three criteria
 - Completed six months as house surgeon in Obstetrics and Gynaecology
 - Has at least one year experience in the practice of Obstetrics and Gynaecology at any hospital that has all facilities
 - Assisted an RMP in 25 cases of medical termination of pregnancy of which at least five have been performed independently in a hospital established or maintained by the government or a training institute approved for this purpose by the government.
- The permission is categorized as “partial” because these providers are restricted by gestational age limits on the use of this method for MTP.
 - According to an MTP Act, including its Rules and Regulations (explanation under Rule 5 of MTP Act Rules), a pregnancy can be terminated medically up to 7 weeks of gestation (provided the

³⁴ Handbook on Medical Methods of Abortion – to expand access to New Technologies for Safe abortion. Ministry of Health and Family Welfare, Government of India. 2016.
http://nrhm.gov.in/images/pdf/programmes/maternal-health/guidelines/MMA_Handbook.pdf

Rules pertaining to the provider qualification and experience and site approvals are adhered to.)

- According to the CAC Provider's Manual (page 61)³¹, while it talks about MMA being offered as an option to all eligible women within 7 weeks of pregnancy, it also mentions in a footnote, "mifepristone + misoprostol (1 tab mifepristone 200 mg + 4 tablets misoprostol 200 mcg each) combi-pack has been approved by the Central Drug Standard Control Organization (CDSCO), Directorate General of Health Services, for the medical termination of intrauterine pregnancy (MTP) for up to 63 days gestation" (viz. 9 weeks)³⁵.
- The MMA Handbook³⁴ (Page 5) says, "Option for MMA should be given to all women coming to a health facility seeking termination of pregnancy up to 7 weeks of gestation". It makes no reference to the use of MMA for gestation beyond 7 weeks.
- Discussions with the experts at the meeting revealed that while there are policy restrictions on the use of mifepristone and misoprostol combination to terminate pregnancy beyond 7 (or 9) weeks of gestation, in practice a large proportion of the terminations beyond this time frame, including those well into the second trimester, were being performed with "off-label"³⁶ use of these drugs.

³⁵ CDSCO Circular no. F. No. 4-193/2005-DC (Pt-SYN). Dated 19 Mar 2009.

³⁶ Off-label drug use refers to the use of drugs outside the conditions of the product license in terms of dose, patient age, route of administration, indications and contra-indications.
(<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4504053/>)

Task 1.4: Medical management of incomplete abortion with misoprostol (Uterus size up to 13 weeks)								
<p><i>WHO description of task:</i> This includes</p> <ul style="list-style-type: none"> - Recognizing the condition; - Assessing uterine size; and - Administration of oral or buccal misoprostol in the correct dose. <p>[Incomplete abortion can occur after an induced or spontaneous abortion (i.e. miscarriage). The management is identical and the WHO recommendations apply to both situations.]</p>								
	ASHA	Pharmacy worker	Pharmacist	AYUSH doctor	ANM	Nurse	MBBS doctor	Ob-Gyn
WHO								
India	Not permitted	Not permitted	Not permitted	Absence of guidelines	Absence of guidelines	Absence of guidelines	Partially permitted	Partially permitted

Gap # 1.4.1 – AYUSH doctors, Nurses and ANMs not permitted to manage first trimester incomplete abortions using medical methods.

Cadre: AYUSH doctor, ANM, Nurse

Explanation:

- The management of incomplete abortion is not subject to the MTP Act (including its Rules and Regulations.)
- The CAC Provider’s Manual³¹, which discusses the use of misoprostol for incomplete abortion mentions it only in the context of a failed MMA and its management by an RMP only. It is presumed that as these cadres are not permitted to provide MMA, they are also not permitted to manage complications following MMA.
- The Operational Guidelines for CAC²⁹ services do not make any reference to the use of misoprostol for incomplete abortions.
- None of the CAC related policy and training documents make any reference to AYUSH providers. As they have been awarded special permissions, through government orders, to perform other RMH related activities (like provision of delivery care), the absence of any such order for CAC related services including for management of incomplete abortion, is presumed to be a “not-permitted” status for this cadre.

Gap # 1.4.2 – Restrictions on the use of medical methods by MBBS doctor for management of first trimester incomplete abortions.

Cadre: MBBS doctor, Ob-Gyn

Explanation:

- The management of incomplete abortion is not subject to the MTP Act (including its Rules and Regulations).
- The permission is “partial” because,
 - The complete spectrum of incomplete abortions is not covered. The Provider’s Manual³¹ for CAC (page 69), discusses use of misoprostol for management of incomplete abortion only in cases where this is due to a failed MMA. Even in this, it is restricted to specific cases where

- the gestational sac is visible on an ultrasound but is not viable. There is no reference to management of spontaneous onset incomplete abortions using misoprostol.
- In the Trainee Handbook on Pregnancy Care by Medical Officers³⁷ (page 98), the management of incomplete spontaneous abortion up to 12 weeks of gestation is restricted to the use of VA only, and there is no mention of administration of misoprostol as an option.
 - The permission given by DCGI for use of misoprostol by MBBS doctors includes only prevention and management of PPH, cervical priming for abortions and for the MTP process (to be used in combination with mifepristone). There is no reference to use of misoprostol for management of incomplete abortions in the DCGI permissions.

³⁷ Trainees' Handbook for Training of Medical Officers in Pregnancy Care and Management of Common Obstetric Complications. Ministry of Health and Family Welfare, Government of India. August 2009. http://nrhm.gov.in/images/pdf/programmes/maternal-health/guidelines/trainees_handbook_for_training_of_mos_in_preg_care.pdf

Task 2: Management of Abortion and Post-abortion Care BEYOND 12 WEEKS

Task 2.1: Dilatation and Evacuation (D&E) for induced abortion								
Sub-task 2.1.1: Cervical priming with osmotic dilators								
<i>WHO description of task:</i> This includes								
- Placing osmotic dilators (like laminaria tent) 6-24 hours before the procedure.								
	ASHA	Pharmacy worker	Pharmacist	AYUSH doctor	ANM	Nurse	MBBS doctor	Ob-Gyn
WHO								
India	Not permitted	Not permitted	Not permitted	Not permitted	Not permitted	Not Permitted	Partially conditionally permitted	Partially permitted
Sub-task 2.1.2: Cervical priming with medications								
<i>WHO description of task:</i> This includes								
- Either mifepristone, given orally, 24-48 hours before the procedure; or								
- misoprostol given sublingually or vaginally 2-3 hours before the procedure.								
	ASHA	Pharmacy worker	Pharmacist	AYUSH doctor	ANM	Nurse	MBBS doctor	Ob-Gyn
WHO								
India	Not permitted	Not permitted	Not permitted	Not permitted	Not permitted	Not permitted	Partially conditionally permitted	Partially permitted
Sub-task 2.1.3: The evacuation process								
<i>WHO description of task:</i> This includes								
- Cervical priming; and								
- Uterine evacuation.								
	ASHA	Pharmacy worker	Pharmacist	AYUSH doctor	ANM	Nurse	MBBS doctor	Ob-Gyn
WHO								
India	Not permitted	Not permitted	Not permitted	Not permitted	Not permitted	Not permitted	Partially conditionally permitted	Partially permitted

Gap # 2.1.1 – Gestational age and other restrictions for using D&E and a method for second trimester abortions

Cadre: MBBS doctor, Ob-Gyn

Explanation:

- For both the MBBS doctor and well as the Ob-Gyn, the permission for D&E is “partial” because,

³⁸ If the cervical priming is initiated under supervision of the health care provider responsible for performing D&E.

- According to the CAC Provider's Manual³¹ (page 145), the gestational age limit for use of this method is 15 weeks only; thus it does not cover the period from 15-20 weeks that are allowed under the law. The Manual refers to the WHO 2012 guidelines on Safe Abortion³⁹ for this recommendation on restricting gestational age. The alternate surgical procedure mentioned in the Provider's manual³¹ is a hysterotomy.
- The CAC guidelines 2010⁴⁰ (page 56) states that the recommended gestational age for use of D&E is 13-16 weeks. The alternate procedure that it recommends is extra-amniotic instillation of ethacridine lactate.
- Anecdotal evidence⁴¹ as well as discussions with the experts at the meeting revealed that very few providers are currently using this method, as the skills for this procedure are almost obsolete even among qualified Ob-Gyn. Due to safer methodologies available, especially in the form of medical methods of abortion, providers are not resorting to D&E.
- For MBBS doctors there appears to be a discrepancy in the various documents,
 - According to the MTP Act, an MBBS doctor is permitted to perform second trimester abortions provided s/he fulfills certain conditions (viz. an experience either for 6 months as a house-officer in an Ob-Gyn department or a 1 year experience in the Ob-Gyn department of a "fully equipped hospital")
 - According to the CAC Operational Guidelines²⁹ (page 4), only an Ob-Gyn is permitted to conduct second trimester abortions whether at the level 3 public sector or approved private sector facilities.
 - Similarly, the CAC Provider Manual³¹ (page 145) too says that this procedure should be done by a Gynecologist only at the appropriate facility level.
- For MBBS doctors, the permission is "conditional" because of the additional training requirements set forth in the MTP Act Rules, according to which, a non-specialist medical practitioner is permitted to conduct second trimester MTPs only if s/he has undergone one of the following additional training requirements.
 - Completed six months as house surgeon in Obstetrics and Gynaecology
 - Has at least one year experience in the practice of Obstetrics and Gynaecology at any hospital that has all facilities

Gap # 2.1.2 – AYUSH doctors, Nurses and ANMs not permitted to perform cervical priming (before D&E).

Cadre: AYUSH doctor, Nurse, ANM

Explanation:

³⁹ Safe Abortion: Technical and policy Guidelines for Health Systems. Second Edition. World Health Organization. 2012.

⁴⁰ Comprehensive Abortion Care Training and Service Delivery Guidelines. Ministry of Health and Family Welfare, Government of India. 2010. http://nrhm.gov.in/images/pdf/programmes/maternal-health/guidelines/abortion_care_training.pdf

⁴¹ Ipas Development Foundation's field level experience.

- Cervical priming before surgical evacuation in second trimester abortions is part of the overall procedure of second trimester abortion and is listed as a sub-task of D&E in the CAC technical and training documents. However, none of the CAC policy, technical and training documents list out separate cadres, beyond the ones performing the overall D&E procedure, who are permitted to perform individual sub-tasks such as cervical priming. Hence the lack of permission for the overall procedure is construed to be a lack of permission for the sub-tasks too.
- MTP Act allows only Registered Medical Practitioners (RMPs), as defined under the Indian Medical Council Act 1956, to terminate pregnancy.
- The Indian Medical Council Act, 1956 captures only MBBS and other allopathic specializations under its registered schedules.
 - None of the AYUSH qualifications are recognized under this Act and hence they are not defined as RMPs.
 - The nursing personnel, whether GNM, B.Sc. Nursing or ANM, are also not recognized as RMPs.









Therefore, neither the AYUSH providers, nor the Nurses and ANMs can perform MTPs, including second trimester abortions, either the complete procedure or any of its sub-tasks.

Gap # 2.1.3 – Lack of options for methods for used cervical priming

Cadre: MBBS doctor, Ob-Gyn

Explanation:

- As mentioned in Gap # 2.1.1 above, in India, D&E is not a preferred method of providers for second trimester abortions. In addition, anecdotal evidence reveals that even in cases where D&E is performed, cervical priming is done using misoprostol. Osmotic dilators are neither easily available nor preferred by the providers.

Task 2.2: Medical abortion with mifepristone + misoprostol or misoprostol alone								
<p><i>WHO description of task³⁹:</i></p> <ul style="list-style-type: none"> - Assessing gestational age; - Administration of initial dose of mifepristone (if available) followed by multiple doses of misoprostol; - Pain management; - Is a facility-based procedure; - Keeping the woman under observation until the process is complete. 								
	ASHA	Pharmacy worker	Pharmacist	AYUSH doctor	ANM	Nurse	MBBS doctor	Ob-Gyn
WHO						 ⁴²		
India	Not permitted	Not permitted	Not permitted	Not permitted	Not permitted	Not permitted	Conditionally permitted	Conditionally Permitted

Gap # 2.2.1 – Gestational age restrictions for performing second trimester abortions using medical methods

Cadre: MBBS doctor, Ob-Gyn

Explanation:

- In India, MTP using medical methods is not permitted beyond 7 weeks of gestation.
 - According to the MTP Act (Explanation under Rule 5 of MTP Act Rules), an RMP is permitted to conduct and abortion using medical methods (mifepristone + misoprostol combination) only till 7 weeks of pregnancy.
 - According to the CAC Provider’s Manual³¹ (page 61), while it talks about MMA being offered as an option to all eligible women within 7 weeks of pregnancy, it also mentions in a footnote, “mifepristone + misoprostol (1 tab mifepristone 200 mg + 4 tablets misoprostol 200 mcg each) combi-pack has been approved by the Central Drug Standard Control Organization (CDSCO), Directorate General of Health Services, for the medical termination of intrauterine pregnancy (MTP) for up to 63 days gestation” (viz. 9 weeks)³⁵.
 - The CAC Provider’s Manual³¹ while discussing available methods for second trimester abortions talks about medical methods not being permitted by DCGI, but nonetheless goes on to explain the complete procedure as “WHO recommends this method as the safest method for second trimester termination”.
 - The CAC guidelines⁴⁰ (Page 66) also discusses the procedure for MMA in the second trimester. However, in this document (which is older than the Provider’s Manual), the same is provided as an annexure (Annexure 7.1) rather than in the main body of the document.
- Based on the discussion with the experts at the meeting, as well as anecdotal evidence, a large proportion of pregnancy terminations in the second trimester are using drugs like mifepristone and misoprostol combination. This, the experts explained, is the off-label³⁶ use of drugs. Despite being an approved drug, and being used for a condition which is in accordance with accepted international standards, whether or not such “off-label” use can stand the test in a court of law,

⁴² Only when there is easy access to appropriate surgical back-up in case of incomplete abortion and other complications.

is unclear. According to an editorial in the Indian Journal of Anesthesiology⁴³, off-label use of drugs is considered legal unless it violates ethical or safety guidelines. In this case, the safety of MMA drugs for second trimester abortions is proven through various studies and WHO, in its 2012 guidelines on Safe Abortion, recommends this as one of the methods for safe abortion.

Gap # 2.2.2 – Nurses not permitted to provide second trimester abortions using medical methods.









Cadre: Nurse

Explanation:

- Other than the issue related to the permission to use MMA beyond 7 (or 9) weeks of gestation mentioned under Gap # 2.2.1 above, the Nurses face an additional barrier in practice. According to the MTP Act, only an RMP can provide MTP services. The definition of an RMP, as defined under the Indian Medical Council Act does not include a qualified nurse as an RMP.

⁴³ Gota V, Divatia JV. Off label use of drugs: An evil or a necessity? Indian J Anaesth 2015. 59; 767-8. (<http://www.ijaweb.org/article.asp?issn=0019-5049;year=2015;volume=59;issue=12;spage=767;epage=768;aulast=Gota>)

Task 3: Recognizing and managing non-life threatening complications

Task 3.1: Initial management of non-life-threatening post-abortion infection								
<p><i>WHO description of task:</i> This includes</p> <ul style="list-style-type: none"> - Recognizing the complication; - Stabilizing the woman; - Providing oral or parenteral antibiotics; and - Referral to appropriate health care provider/facility for definitive care. 								
	ASHA	Pharmacy worker	Pharmacist	AYUSH doctor	ANM	Nurse	MBBS doctor	Ob-Gyn
WHO				 ²⁷				
India	Not permitted ⁴⁴	Absence of guidelines	Absence of guidelines	Absence of guidelines	Permitted	Permitted	Permitted	Permitted









Gap # 3.1.1 – AYUSH doctors not permitted to provide initial management of post-abortion infection.

Cadre: AYUSH doctor

Explanation:

- The management of abortion related complications is not subject to the MTP Act, including its Rules and Regulations.
- None of the CAC related policy and training documents make any reference to AYUSH providers. As they have been awarded special permissions, through government orders, to perform other RMH related activities (like provision of delivery care), the absence of any such order for CAC related services including for management of abortion related complications, is presumed to be a “not-permitted” status for this cadre.

⁴⁴ Permitted to recognize the danger signs (signifying complications) and refer the woman to appropriate facility level for care.

Task 3.2: Initial management of non-life-threatening post-abortion hemorrhage								
<p><i>WHO description of task:</i> This includes</p> <ul style="list-style-type: none"> - Recognizing the complication; - Stabilizing the woman; - Providing IV fluids; and - Referral to appropriate health care provider/facility for definitive care. 								
	ASHA	Pharmacy worker	Pharmacist	AYUSH doctor	ANM	Nurse	MBBS doctor	Ob-Gyn
WHO				 ²⁷				
India	Not permitted ⁴⁴	Absence of guidelines	Absence of guidelines	Absence of guidelines	Permitted	Permitted	Permitted	Permitted









Gap # 3.2.1 - AYUSH doctors not permitted to provide initial management of post-abortion hemorrhage.

Cadre: AYUSH doctor

Explanation:

- Same as Gap # 3.1.1 above.

Task 4: Counselling and information provision

Task 4.1: Provision of general information on safe providers, laws, contraception options								
<p><i>WHO description of task:</i> This includes Provision of GENERAL INFORMATION related to safe abortion care (to not only women seeking these services, but also other women or men), for example</p> <ul style="list-style-type: none"> - Where and how to obtain methods of contraception; - Where and how to obtain safe, legal abortion services; - Cost information; - Specifics of local laws; and - Importance of seeking care early. 								
	ASHA	Pharmacy worker	Pharmacist	AYUSH doctor	ANM	Nurse	MBBS doctor	Ob-Gyn
WHO		 ⁴⁵						
India	Permitted	Absence of guidelines	Absence of guidelines	Permitted ⁴⁶	Permitted	Permitted	Permitted	Permitted

Gap # 4.1.1 – Pharmacists and pharmacy workers not involved in provision of information on abortion services.









Cadre: Pharmacists and pharmacy workers

Explanation:

- The provision of information related to MTP is not subject to the MTP Act (including its Rules and Regulations).
- None of the CAC related policy or training documents make any reference to the pharmacists and/or pharmacy workers. It is also not known whether this component is part of their pre-service education.

⁴⁵ Only when they are working a) Under the supervision of pharmacist; and b) With access to referral facilities.

⁴⁶ The AYUSH providers also use the “Guidelines on Ante Natal Care and Skilled Attendance at Birth by ANMs/LHVs /SNs” (MoHFW, GOI, 2009) for provision of pregnancy and delivery care, in which, under the section on “Early Registration of Pregnancy” (page 9), it talks about providing the woman the needed information about abortion services including where to go should she need these services in cases of an unplanned pregnancy.

Task 4.2: Pre- and post-abortion counselling								
<i>WHO description of task:</i> This includes <ul style="list-style-type: none"> - Provision of scientifically accurate and easy-to-understand information to all women undergoing an abortion; and - Voluntary counselling to women who request it. - Counselling is more than information provision and refers to <ul style="list-style-type: none"> * A focused interactive process; * Through which woman voluntarily receives * Support, information and non-directive guidance from * A trained person. [Counselling requires a much higher level of specific knowledge than providing general information about safe abortion care.]								
	ASHA	Pharmacy worker	Pharmacist	AYUSH doctor	ANM	Nurse	MBBS doctor	Ob-Gyn
WHO	 ⁴⁷			 ²⁷				
India	Permitted ⁴⁸	Not permitted ⁴⁹	Not permitted ⁴⁹	Absence of guidelines	Permitted	Permitted	Permitted	Permitted

Gap # 4.2.1 – AYUSH doctors not involved in counselling on abortion care.

Cadre: AYUSH doctor

Explanation:









- The provision of counselling related to MTP is not subject to the MTP Act (including its Rules and Regulations).
- None of the CAC related policy and training documents make any reference to AYUSH providers. As they have been awarded special permissions, through government orders, to perform other RMH related activities (like provision of delivery care), the absence of any such order for CAC related services including provision of pre- and post-counselling for abortion, is presumed to be a “not-permitted” status for this cadre.

⁴⁷ Where health care providers performing the procedure are unavailable for counselling or woman needs additional support.

⁴⁸ Information on safe abortion - including when (legal provisions) and where a woman can seek abortion, and the various methods for the same - is described in the ASHA module 5. ASHA modules are used for their training and form a basis for describing their job responsibilities.

⁴⁹ The expert group was of the opinion that the pharmacists and pharmacy workers in India were “not permitted” to counsel the woman on safe abortion as they are not trained counsellors

Task 5: Post-abortion contraception provision⁵⁰

Task 5.1: Insertion and removal of IUCDs								
	ASHA	Pharmacy worker	Pharmacist	AYUSH doctor	ANM	Nurse	MBBS doctor	Ob-Gyn
WHO				 ²⁷				
India	Not permitted	Not permitted	Not permitted	Partially permitted	Partially conditionally permitted	Partially conditionally permitted	Permitted	Permitted

Gap # 5.1.1 – Restrictions on AYUSH doctors, Nurses and ANMs for provision of post-abortion IUCD services.

Cadre: AYUSH doctor, Nurses and ANMs

Explanation:

- According to the CAC Operational Guidelines²⁹ (Page 5), both Nurses and ANMs are permitted to provide Post-abortion Family Planning (PAFP), including post-abortion IUCD (PAIUCD). No further details are provided therein.
- The permission for ANMs and Nurses is considered “partial” because according to the PAFP Operational Guidelines⁵¹
 - “Nursing personnel” are permitted to insert post-abortion IUCD (PAIUCD). However, it does not define who all are included under “Nursing personnel”.
 - On the flip side, ANMs are counted as front-line workers (along with ASHAs) for orientation program on “PAFP contraceptive choices and options.”
 - The permission is restricted till the first trimester only.
- The permission for ANMs and Nurses is considered “conditional” because according to the PAFP Operational Guidelines⁵¹
 - The procedure can be done at only PHC or higher centers.
 - A one-day additional orientation / training is needed for those already trained in IUCD and PPIUCD insertion. (This includes a wide range of provider cadres including ANMs)

Thus, there appears to be a lack of clarity on the role of ANMs in PAIUCD provision according to the PAFP guidelines.

- There is no reference to the AYUSH providers in any of the CAC policy or training documents, including the PAFP documents. However, they are assumed to be “partially permitted” because

⁵⁰ The WHO task-shifting guidelines does not provide a detailed description of these tasks, presumably because provision of contraception is not an “abortion-specific” task. For the purpose of this document, provision of each of the contraceptive methods has been presumed to involve assessing the eligibility of the woman, provision/administration/insertion of the method and its removal (wherever applicable).

⁵¹ Post-abortion Family Planning Operational Guidelines. D.O. No. N11019/2/2015-FP. Dated 24th August 2016.

- While the AYUSH providers are permitted to insert IUCDs, and the reference manual for IUCD for AYUSH providers⁵² (Page 36) mentions both post- first trimester and post second trimester abortions as timings when an IUCD can be inserted, the manual does not clarify whether the providers are permitted to carry out the procedure post-abortion, in both the first and second trimester.
- Additionally, there is no reference to the AYUSH doctor in the PAFP Operational guidelines.
- Like for other permissions under RMH, their eligibility has been assumed to be, at a minimum, similar to that of the nursing personnel.

⁵² IUCD Reference Manual for AYUSH Doctors. Ministry of Health and Family Welfare, Government of India. January 2014.

http://nrhm.gov.in/images/pdf/programmes/family-planing/guidelines/IUCD_Ref_Manual_for_AYUSH_Doctors-Jan_2014.pdf

Task 5.2: Insertion and removal of implants								
	ASHA	Pharmacy worker	Pharmacist	AYUSH doctor	ANM	Nurse	MBBS doctor	Ob-Gyn
WHO				 Error! Bookmark not defined. ²⁷ and 53	 54			
India	Not permitted	Not permitted	Not permitted	Not permitted	Not permitted	Not permitted	Not permitted	Not permitted

Gap # 5.2.1 – Contraceptive hormonal implants not approved for use in India









Cadre: Ob-Gyns, MBBS doctors, AYUSH doctors, Nurses and ANMs

Explanation:

- Implants are not yet approved for use in India.

⁵³ In addition, they need special training on implant insertion and removal.

⁵⁴ Within the context of targeted monitoring and evaluation.

Task 5.3: Initiation and continuation of injectable contraceptives								
WHO description of task: This includes								
	ASHA	Pharmacy worker	Pharmacist	AYUSH doctor	ANM	Nurse	MBBS doctor	Ob-Gyn
WHO	 54	 55		 27				
India	Not permitted	Not permitted ⁵⁶	Not permitted ⁵⁶	Partially Permitted	Partially Permitted	Partially Permitted	Permitted	Permitted

Gap # 5.3.1 – ASHAs, pharmacists and pharmacy workers not permitted to administer injectable contraceptives (following abortions).

Cadre: ASHAs, Pharmacists and Pharmacy workers.

Explanation:

- In the Reference Manual for Injectable Contraceptives⁵⁷, the listing of the eligible providers (page 37) for this method of contraception does not include ASHAs, pharmacists or pharmacy workers.
- The PAFP Operational guidelines⁵¹ do not specify any information regarding the provision of injectable contraceptives following abortion.
- There is no reference to pharmacists or pharmacy workers in either the CAC or the family planning related policy and/or training documents.

⁵⁵ Under the supervision of a pharmacist

⁵⁶ According to the Expert group, the pharmacist and pharmacy worker are not permitted to administer injectable contraceptives as they are not trained to provide injections. Additionally there are privacy issues related to provision of the same at pharmacies / chemist shops.









⁵⁷ Reference Manual for Injectable Contraceptive (DMPA). Ministry of Health and Family Welfare, Government of India. March 2016. http://nrhm.gov.in/images/pdf/programmes/family-planing/guidelines/Reference_Manual_Injectable_Contraceptives.pdf

Gap # 5.3.2 – Restrictions on AYUSH doctors, Nurses and ANMs for providing injectable contraceptives (following abortions).

Cadre: AYUSH doctors, Nurses and ANMs.

Explanation:

- In the Reference Manual for Injectable Contraceptives⁵⁷, the listing of the eligible providers (page 37) for this method of contraception includes Nurses, ANMs and AYUSH doctors along with the MBBS doctor.
- The permission for the first three cadres is considered to be “partial”, as it says, “The first shot must be administered under the guidance of a trained MBBS doctor after proper screening. Subsequent shots may be administered by trained AYUSH doctor, SN/LHV/ANM.”
- Besides, as added by the experts at the meeting, injectable contraceptives are Schedule H drugs. According to the Drugs and Cosmetics Act, these are available based on a prescription only and currently, only an allopathic (MBBS) doctor can write a prescription for these drugs.

Task 5.4: Tubal ligation								
WHO description of task: This includes								
	ASHA	Pharmacist	Pharmacy worker	AYUSH doctor	ANM	Nurse	MBBS doctor	Ob-Gyn
WHO								
India	Not permitted	Not permitted	Not permitted	Not permitted	Not permitted	Not permitted	Permitted	Permitted

No gaps identified.

PART B
Recommendations for
Task-shifting for
CAC

Changes recommended for improving task shifting under CAC

The first version of the background note that was shared with the experts at the meeting in February 2017 carried task-wise recommendations for enhancing task-shifting in order to improve access to CAC. Those recommendations were based on the gaps (between the WHO recommendations and the Indian scenario) that were identified and listed in the mapping section (Part A: Section 3). These recommendations were drafted as an “academic” exercise, i.e. by answering the simple question - “What would be required for the Indian scenario to match the WHO recommendations?” No biases or filters in terms of effectiveness and/or feasibility of the change was applied. Rationale for the proposed change was also included in the first version of the document. The rationale included primarily similar tasks being done by that particular cadre and/or evidence regarding the safety of proposed task shifting. The purpose was to present the complete picture to the experts and hear from them about the recommendations listed in the document and seek inputs and suggestions on which ones to proceed with.

The experts were asked to think of each recommendation from primarily two perspectives – (i) the (potential) impact of the proposed change in terms of the improvement in access to CAC and/or quality of CAC; (ii) the feasibility of bringing about the said change with reference to multiple factors like the level of change required, the proposed amendment to the MTP Act etc.

The following is a summary of the expert group discussion and decision on each of the recommended changes in the original document. They have been listed according to the gaps identified in Part A: Section 3 (Mapping recommendations for CAC related tasks and sub-tasks) of this document in order to maintain comparability between the pre-meeting and this version of the document. Any additional recommendations from the group have also been included here.

Colour coding: The recommendations that were accepted by the Expert Group have been coded **green**, while the ones that were rejected have been coded **red**. However, there were some where there was a “partial” agreement, that is, they were accepted subjected to a few significant modifications. Such cases have been colored **yellow**. In most of these “yellow” recommendations, the language of the recommendation has been suitably modified in the current document to reflect the proposed changes. The key elements of the modification have been underlined to highlight the same.

Task 1: Management of abortion and Post-abortion Care in the FIRST TRIMESTER

Task 1.1: Vacuum aspiration for induced abortion

Gap 1.1.1: AYUSH doctors and Nurses not permitted to provide VA for first trimester abortions

<p>Recommendation (original):</p> <p>LEGAL: Expansion of the definition of RMP under the MTP Act to also include qualified AYUSH providers (all except Yoga and Naturopathy providers) and Nurses. The additional training needs as required for a non-specialist MBBS doctor may also apply in this case.</p>
<p>Recommendation (revised, if any):</p> <p>Under the MTP Act, <u>replace the term RMP with a “registered health professional”</u>, which includes MBBS / Allopathic doctors, registered AYUSH doctors, Nurses and ANMs, as persons who are eligible to provide MTP services.</p> <p>The Rules under the Act should specify the various methods that <u>additional cadres</u> beyond allopathic doctors (i.e. AYUSH doctors, Nurses and ANMs) would be permitted to use for providing safe abortion services. Under the current scenario, these cadres may be permitted to provide MMA services only.</p>
<p>Rationale:</p> <ul style="list-style-type: none">• As the definition of RMP has been primarily picked up from the Indian Medical Council Act and the MTP Act adds additional requirements to the same, the group felt that the definition cannot be “expanded” as was mentioned in the original recommendation. Instead, it can be “replaced” by a new terminology of registered health professional. This new term is already in use in the proposed amendment of the MTP Act that is pending approval in the Parliament.• Given the safety and effectiveness of medical methods of abortion (MMA), the need and practice of VA is reducing and is expected to reduce further• Ensuring quality of services provided in provision of surgical methods by additional cadres like AYUSH doctors, Nurses and ANMs will be challenging, and this may cause more harm than benefits.• There was a fear among the experts that permitting use of surgical methods of abortion for these additional cadres might also increase the use of non-recommended methods (like D&C and check curettage following MMA) by these cadres, owing to lack of monitoring of quality of both the training as well as the service provision.• ANMs are primarily ambulatory workers, and not many services are being provided at the sub-centre. Therefore, the infrastructure and support system to allow them to provide these services did not exist.

<p>Impact: With the need and use of VA reducing, the experts did not anticipate a significant impact of this recommendation.</p>	<p>Feasibility The experts felt that this was a difficult recommendation to implement, due to various reasons:</p> <ul style="list-style-type: none"> • An amendment to the MTP Act was to be tabled in the Parliament on the recent session. In this amendment, the definition of a “registered health professional” is already provided. Assuming the proposed amendment is accepted, bringing about further changes through another amendment to the law would be very difficult. • The group anticipated a lot of resistance from the Indian Medical Association to this recommendation. • Give the low rates of VA being used for first trimester abortions (due to increasing reliance on MMA), finding training sites with enough case load would be a big challenge for the training of these additional cadres.
<p>Additional discussions (if any):</p> <ul style="list-style-type: none"> • Training for VA should be done at sites that use this as a method for abortion. Beyond the skills for the method itself, the training should also focus on infection prevention in order to reduce the risk of septic abortions. The training should also include an active discouragement of commonly used methods like D&C and check curettage in order to reduce the risk of uterine perforations. 	

Gap 1.2.2: Restrictions on MBBS doctors for providing VA for first trimester abortions

<p>Recommendation (original): POLICY: Changing the policy guidance to allow MBBS doctors to perform first trimester abortions using VA at all approved facilities where a doctor is available, irrespective of its “level”, starting with the PHC, without any gestational age limits within the first trimester.</p>
<p>Recommendation (revised, if any): None.</p>
<p>Rationale:</p> <ul style="list-style-type: none"> • The need for such restrictions in the national policy probably arose from the difference in infrastructure and human resources at the different levels of public health facilities. The higher the gestational age at the time of performing the abortion, the greater the risk of complications. • Despite there being national standards for the infrastructure, equipment and human resources at various facility levels, there is significant variation across states and districts. Therefore, some are better equipped to handle abortion related complications, should they arise, while others are not. • In light of the above, the group felt that the national policy level guidelines should not specify gestational age limitations for different facility levels for provision of abortion using VA.

<p>Instead, it should be left to the states to decide whether or not they want to keep any restrictions depending on the local scenario related to infrastructure, equipment and HR at the facilities in that particular state.</p> <ul style="list-style-type: none"> • However, in light of the potential complications following VA, the facility providing the services should either also be equipped to handle the complications or should have assured referral linkages with other facilities that can manage these complications. Assured referral comprises of three basic components - assured referral transportation, referral slip, communication, acceptance and readiness by referral facility 	
<p>Impact: Not discussed explicitly. However, overall the group felt that there is a reduction in the use of VA as a method for first trimester abortions. Therefore, it may be inferred that such a change may not have a significant impact in the access to and/or quality of CAC services.</p>	<p>Feasibility Not discussed explicitly. However, as this is a policy level change, it could be easily affected at the level of the Ministry following some meaningful advocacy with the technical leads.</p>
<p>Additional discussions (if any): None</p>	

Additional recommendation

<p>Recommendation (original): LEGAL: From the Rules of the MTP Act, remove the additional training / experience requirements for MBBS (non-Ob-Gyn specialists) doctors.</p>	
<p>Recommendation (revised, if any): Not applicable.</p>	
<p>Rationale:</p> <ul style="list-style-type: none"> • While training is essential for ensuring quality of services, making it mandatory by law restricts the number of providers who were eligible to provide MTP services. • The government is presently training MBBS (non-Ob-Gyn specialists) doctors for similar / more difficult skills like C-section and life-saving anesthesia skills (LSAS). However, these requirements are not part of a legal mandate, but are instead part of the government’s policy and training guidelines. Thus, the training requirements to skill MBBS (non-specialist) doctors to provide MTP services should be shifted to the policy and training guidelines like for other medical and health services. This would also make the training needs more amenable to amendment, as and when it is required. • Given the changes in technology, fixed training requirements may not serve the purpose. It should be the prerogative of the government (Ministry officials) to change this as and when new technology comes in. 	
<p>Impact: Not discussed explicitly.</p>	<p>Feasibility Not discussed explicitly.</p>

	However, as this is a legal change, it may be difficult to bring about, especially in light of the current proposed amendment, which does not carry this change.
<p>Additional discussions (if any):</p> <ul style="list-style-type: none"> • The number of days and/cases required for training should be discussed and decided upon by the Ministry. • Like with other trainings, the Ministry may think of a training certification wherein the trainee will be required to observe, assist and independently perform a pre-defined number of cases. • In order to understand the optimum number of cases required for such trainings, the Ministry may undertake some pilot projects to finalize the training requirements. • It is also important to strengthen the pre-service training of all registered health care practitioners to ensure that they are trained in the provision of MTP services to the extent permissible under the law. For example, observing, assisting and independently performing a defined number of cases may be included as mandatory part of the internship. • The training can also be undertaken on mannequins, which is less risky than practicing on live patients/clients. • There should be additional training for the Ob-Gyn in order to discourage the use of D&C and check curettage as they are no longer recommended surgical techniques for induced or managing incomplete abortions. • There should be a strong directive from the government to stop the use of D&C for MTP. This may include various means such as government orders applicable for the practitioners in the public sector, and involvement of professional associations like FOGSI for private practitioners. 	

Task 1.2: Vacuum aspiration for management of incomplete abortion

Gap 1.2.1: **AYUSH doctors and nurses not permitted to provide VA to manage first trimester incomplete abortions.**

<p>Recommendation (original):</p> <p>POLICY: Permit nurses to perform the procedure for incomplete abortions by making the required change in the operational guidelines as well as expanding the scope of the CAC Provider’s Manual by including them in the list of approved providers.</p> <p>Addition of AYUSH providers as another cadre in the Operational Guidelines and Provider’s Manual and defining tasks for them, including the provision of evacuation for incomplete abortion.</p> <p>The additional training needs as required for a non-specialist MBBS doctor may also apply in this case.</p>	
<p>Recommendation (revised, if any):</p> <p>All registered health care personnel posted <u>at referral facilities</u>, including AYUSH doctors, Nurses and ANMs, should be trained to competency to provide <u>management of incomplete abortion</u>.</p>	
<p>Rationale:</p> <ul style="list-style-type: none"> • Management of incomplete abortions is an important obstetric emergency and personnel need to be trained in its management. • The group felt that that not specifying the method to be used for management in the technical / training documents would make approvals at the government level easier. 	
<p>Impact:</p> <p>Low impact</p> <ul style="list-style-type: none"> • VA is not used very frequently as a method to manage incomplete abortions. (This was an additional reason why it was proposed that the changes to the policy text not be method specific). 	<p>Feasibility</p> <p>High feasibility.</p> <ul style="list-style-type: none"> • Management of incomplete abortions is not covered under the MTP Act, Rules and Regulations. This is a policy change, which is in the hands of the Ministry to change. • If the proposed change does not specify the method, it will be easier to move; as VA is a surgical method, permitting the AYUSH doctors, Nurses and ANMs for this method might result in opposition from the MBBS (allopathic) doctors.
<p>Additional discussions (if any):</p> <ul style="list-style-type: none"> • In response to a special question regarding inclusion of ANMs as a cadre permitted to provide management of incomplete abortions using VA, the experts said that, in line with the recommendation, the provision of management of incomplete abortion should be linked to the level of facility and not with specific cadres. So, if any registered health care provider, including an ANM, is posted at a referral facility s/he should be permitted to undertake tasks for the management of incomplete abortions. However, an ANM posted at the sub-center would not be permitted to undertake any such procedures. 	

Gap 1.2.2: Gestational age and other restrictions on MBBS doctors for providing VA to manage first trimester incomplete abortions.

<p>Recommendation (original): POLICY: Raising the gestational age limit for using VA for incomplete abortion from 12 to 13 completed weeks.</p> <p>Ensuring consistency in the documents – such as clarifying the gestational age for management of incomplete (and inevitable) abortions in the Operational guidelines.</p>	
<p>Recommendation (revised, if any): None.</p>	
<p>Rationale:</p> <ul style="list-style-type: none"> The experts agreed with the rationale provided in the previous version of the background document. No additional rationale was provided. 	
<p>Impact: Not discussed explicitly Based on discussions on rationale, expected to be low, as raising the bar by another week of gestation is not expected to increase access significantly.</p>	<p>Feasibility High.</p> <ul style="list-style-type: none"> This is a policy change, which is in the hands of the Ministry officials. MBBS doctors are permitted to and are conducting the procedure in any case, hence no opposition is anticipated to this change.
<p>Additional discussions (if any): None.</p>	

<p>Recommendation (original): IMPLEMENTATION: Offering clarification to medical officers at PHCs regarding the rules and encouraging them to perform VA for incomplete (and inevitable) abortions up to 13 weeks of gestation at PHC level itself.</p>	
<p>Recommendation (revised, if any): None.</p>	
<p>Rationale:</p> <ul style="list-style-type: none"> Given the decreasing use of VA and increasing reliance on MMA the experts felt that this recommendation did not carry much merit. 	
<p>Impact: Not discussed explicitly Based on discussions on rationale, expected to be low, due to decreasing reliance on VA.</p>	<p>Feasibility Not applicable.</p>
<p>Additional discussions (if any): None.</p>	

Task 1.3: Medical abortion with mifepristone + misoprostol

Gap 1.3.1: **AYUSH doctors, Nurses and ANMs nor permitted to provide first trimester abortions using medical methods.**

<p>Recommendation (original): LEGAL: Expansion of the definition of RMP under the MTP Act to also include qualified AYUSH providers (all except Yoga and Naturopathy providers), Nurses and ANMs</p> <p>The additional training needs as required for a non-specialist MBBS doctor may also apply in this case.</p>	
<p>Recommendation (revised, if any): Under the MTP Act, <u>replace the term RMP with a “registered health professional”</u>, which includes MBBS / Allopathic doctors, registered AYUSH doctors, Nurses and ANMs, as persons who are eligible to provide MTP services.</p>	
<p>Rationale:</p> <ul style="list-style-type: none"> As mentioned under Gap 1.1.1, the primary source for the definition of RMP is the Indian Medical Council Act, and not the MTP Act; the latter only adds caveats to that definition as needed in the context of MTP services. Hence the group suggested that the definition of an RMP cannot be “expanded” (as suggested in the original recommendation) but should be “replaced” by the term “registered health professional”. Hence the language of the recommendation has been amended. The rationale for this came from the discussion under Gap 1.1.1 – i.e. MMA is a safe and effective method of abortion and can easily be provided by non-allopathic practitioners, including AYUSH doctors, nurses and ANMs. 	
<p>Impact: High. This is due to</p> <ul style="list-style-type: none"> Increasing reliance on MMA for first trimester abortions. Increased access to safe abortion services in the first trimester due to additional cadres of legal providers Permitting and training other cadres in MMA is expected to reduce the complications perceived to be arising due to over-the-counter use of MMA drugs by women. 	<p>Feasibility Not discussed.</p>
<p>Additional discussions (if any):</p> <ul style="list-style-type: none"> WHO includes “screening of possible ectopic pregnancy” as a step in the sub-task of assessing eligibility for MMA”. The group felt that this is a difficult skill to acquire and cadres other than 	

MBBS doctors might not be able to perform this. Hence, this element should be removed while following up on the recommendation for the additional cadre.

- As discussed under Gap 1.1.1, the Rules under the MTP Act should specify that while cadres other than MBBS (allopathic) doctors are permitted to provide MMA, they should not be permitted to use VA or any surgical method for induced abortion / MTP.

Gap 1.3.2: Gestational age and other restrictions on MBBS doctors for providing first trimester abortions using medical methods.

Recommendation (original):

Removal of the requirement for RMPs, providing MTP services using MMA, to display a certificate specifying access to an “approved” MTP site.

Recommendation (revised, if any):

None.

Rationale:

- Such a requirement gives the patients and assurance about referral should the need arise.
- It also puts the onus on the provider to have formal tie-ups with referral facilities.
- There is no data / information on whether (or not) this Rule impeded the ability of providers to provide MMA services.

Impact:

Not discussed explicitly, though given the perception that this is not a major impediment to access of services, the impact of this change is expected to low.

Feasibility

Not discussed.

Additional discussions (if any):

The group clarified that this requirement is part of the Rules of the MTP Act, and not the law itself.

Some participants felt that such a legal requirement was not there for other obstetric care services, even though the risk of complications and need for referral was a potential danger in all obstetric cases. For example, any woman who went in for a normal delivery could need a C-section or at other obstetric complication. However, such a certificate is not essential for provision of delivery services.

Recommendation (original):

LEGAL: Enhancing the gestational age up to which MMA can be used safely to cover the complete first trimester (NOTE: According to WHO 2012 guidelines on Safe Abortion (page 3) use of MMA beyond 9 weeks of gestation will require additional/repeated doses of misoprostol compared to only a single dose for pregnancies less than 9 weeks of gestation.)

This change will need to be approved by the DCGI.

Recommendation (revised, if any):

None.

<p>Rationale:</p> <ul style="list-style-type: none"> • As MMA is safe and effective for first trimester abortions, doctors are even now using this method much more than VA (or other surgical techniques). • Even though the use of these drugs is not approved beyond 7 (or 9) weeks, they are being used “off-label”, i.e. use of a drug for indications beyond what it is approved for. (<i>See definition of “off-label” under Part A: Section 3</i>). • Once approved, it would give “legal sanctity” to the MMA regimen even beyond 7 (or 9 weeks) of gestation, and save the health personnel from potential harassment and/or litigation. 	
<p>Impact:</p> <p>Not discussed explicitly.</p> <p>Given the current off-label use for first trimester abortions even beyond the 7 (or 9) weeks specified in the law and/or policy guidelines, it is unlikely to have much impact on increasing access to MMA.</p>	<p>Feasibility</p> <p>Not discussed.</p>
<p>Additional discussions (if any):</p> <ul style="list-style-type: none"> • In other countries, off-label use is not illegal. However, the provider needs to counsel the patient / client regarding the issue and let him/her decide whether or not to accept that treatment. • There is no clarity on the legality of off-label use of drugs in India, even though a few journal articles were quoted at the meeting (and shared in the Part A: Section 3 on Mapping) that state that the legal status of off-label use in India is similar to other countries. • In this scenario, some experts even felt that a change may not be required. However, others felt that giving explicit legal sanction to MMA for the complete first trimester is important given the sensitive nature of the MTP Act and its monitoring. While no provider has ever faced legal persecution for use of MMA drugs beyond 7 (or 9) weeks, it would not be prudent to wait for such an untoward scenario before moving for necessary approvals from DCGI. 	

Task 1.4: Medical management of incomplete abortion with misoprostol (Uterus size up to 13 weeks)

Gap 1.4.1: **AYUSH doctors, Nurses and ANMs not permitted to manage first trimester incomplete abortions using medical methods.**

Recommendation (original):	
POLICY: Permit the ANMs and Nurses to administer misoprostol for incomplete abortions by making the required addition in the Operational Guidelines as well as expanding the scope of the CAC Provider's Manual by including them in the list of providers.	
Addition of AYUSH providers as another cadre in the Operational Guidelines and Provider's Manual and defining tasks for them, including the administration of misoprostol for management of incomplete abortion.	
Recommendation (revised, if any):	
All registered health care personnel posted <u>at referral facilities</u> , including AYUSH doctors, Nurses and ANMs, should be trained to competency to provide <u>management of incomplete abortion</u> .	
Rationale:	
<ul style="list-style-type: none"> The revised recommendation and discussion were taken from the one under Gap 1.2.1, viz. management of incomplete abortion should be linked to the level of the facility (referral facilities) and not the cadre of the registered health care personnel. No method for management of incomplete abortion was specified. 	
Impact:	Feasibility
Not discussed.	Not discussed.
Additional discussions (if any):	
<ul style="list-style-type: none"> None. 	

Gap 1.4.2: **Restrictions on the use of medical methods by MBBS doctor for management of first trimester incomplete abortions.**

Recommendation (original):	
POLICY: Inclusion of management of the complete spectrum of incomplete abortions, including spontaneous incomplete abortions, using misoprostol in the CAC policy and training documents.	
Recommendation (revised, if any):	
None.	
Rationale:	
<ul style="list-style-type: none"> Management of incomplete abortions does not vary based on its onset – that is whether it is spontaneous or induced. While management of spontaneous abortions, including incomplete abortions, is part of the BEmOC guidelines, it also needs to be explicitly described in the CAC guidelines. 	
Impact:	Feasibility
Not discussed.	Not discussed.
Additional discussions (if any):	

- None.

Recommendation (original):

POLICY: Inclusion of the management of incomplete abortions as one of the specified uses for misoprostol in the DCGI guidelines on indications for drug use.

Recommendation (revised, if any):

None.

Rationale:

- When the drug is approved for inducing abortions / MTP, there is no reason for not extending its use to management of incomplete abortions.

Impact:

Not discussed.

Feasibility

Not discussed.

Additional discussions (if any):

- None.

Task 2: Management of Abortion and Post-abortion Care BEYOND 12 WEEKS

Task 2.1: Dilatation and Evacuation (D&E) for induced abortion BEYOND 12 weeks

Gap 2.1.1: Gestational age and other restrictions for using D&E and a method for second trimester

Recommendation (original): POLICY: Expansion of the gestational age limit for performing D&E in the second trimester to match the legal allowable limit for MTP (presently 20 weeks).	
Recommendation (revised, if any): None.	
Rationale: <ul style="list-style-type: none"> • This technique is fast becoming obsolete. • Ob-Gyn practitioners at the meeting shared that the procedure is very traumatic, especially psychologically, for both the mother and the provider. 	
Impact: Low. Even if implemented, very few providers will use the technique; only those with facilities for provision of general anesthesia and USG may use this.	Feasibility Low. Even if implemented, the training of providers in this technique will be difficult due to the low case load (based on data from IDF supported abortion centers)
Additional discussions (if any): <ul style="list-style-type: none"> • None. 	

Recommendation (original): IMPLEMENTATION: Train providers to use this method (D&E) for second trimester abortions.	
Recommendation (revised, if any): None.	
Rationale: <ul style="list-style-type: none"> • The rationale is the same as provided for the recommendation above. • Due to very low rates of implementation of the method, there will be hardly any case load for ensuring effective training. 	
Impact: Not discussed.	Feasibility Low.
Additional discussions (if any): <ul style="list-style-type: none"> • None. 	

Gap 2.1.2: **AYUSH doctors, Nurses and ANMs nor permitted to perform cervical priming (before D&E).**

<p>Recommendation (original): POLICY: Permission for qualified AYUSH providers (all except Yoga and Naturopathy providers), Nurses and ANMs to perform cervical priming, using either osmotic dilators or medications like misoprostol (as permitted in the WHO task-shifting guidelines) to prepare for second trimester abortion using D&E.</p> <p>The additional training needs as required for a non-specialist MBBS doctor may also apply in this case.</p>	
<p>Recommendation (revised, if any): Permission for qualified AYUSH providers (all except Yoga and Naturopathy providers), Nurses and ANMs to perform cervical priming, by <u>administering medications like misoprostol</u> (as recommended in the WHO task-shifting guidelines) to prepare for second trimester abortion using D&E, <u>following assessment by and under the supervision of an MBBS doctor</u>, and at <u>referral facilities</u> only.</p>	
<p>Rationale:</p> <ul style="list-style-type: none"> • The experts did not agree to permit the additional cadres to insert osmotic dilators for cervical priming as it requires training. • Additionally, the use of osmotic dilators is gradually becoming insignificant in terms of numbers. • The permission is also linked to the facility level, as second trimester abortions can only be provided at registered facilities, which within the public health sector are referral facilities. • The experts also were wary of the ability of the non-allopathic doctors and nursing cadres to assess the woman's eligibility to undergo the process. That is why, in line with the WHO recommendation, it was specified that the procedure be undertaken following assessment by an MBBS doctor and under his/her supervision. 	
<p>Impact: Not discussed.</p>	<p>Feasibility Not discussed.</p>
<p>Additional discussions (if any):</p> <ul style="list-style-type: none"> • Osmotic dilators are not used presently due to difficulties in procuring and sterilizing them. 	

Gap # 2.1.3: **Lack of options for methods used for cervical priming**

<p>Recommendation (original): IMPLEMENTATION: Encourage providers to use osmotic dilators too for cervical priming, wherever available.</p>	
<p>Recommendation (revised, if any): None.</p>	
<p>Rationale:</p> <ul style="list-style-type: none"> • Use of osmotic dilators is no longer in vogue. • Compared to medicines like misoprostol, using osmotic dilators for cervical dilatation has the following disadvantages <ul style="list-style-type: none"> - Being trans-cervical, it is a more invasive procedure. - The procedure takes longer to conduct. 	

<ul style="list-style-type: none">- The procedure takes longer to have an effect- There is an increased risk of infection as one cannot sterilize osmotic dilators like laminaria tents.	
Impact: Not discussed.	Feasibility Not discussed.
Additional discussions (if any): None.	

Task 2.2: Medical abortion with mifepristone + misoprostol or misoprostol alone BEYOND 12 weeks

Gap 2.2.1: Gestational age restrictions for performing second trimester abortions using medical methods.

<p>Recommendation (original): POLICY: Expansion of the gestational age limit for using mifepristone and misoprostol to match the legal allowable limit for MTP (presently 20 weeks). This will involve getting an approval from the DCGI for the same, for not just the combi-pack but also for misoprostol alone.</p>	
<p>Recommendation (revised, if any): None.</p>	
<p>Rationale:</p> <ul style="list-style-type: none"> • No other method is as safe and effective as this method. (See under Gap 2.1.1 for the issue related to surgical techniques like D&E) • Even currently, providers, especially those in the private sector, are using these medicines “off-label” to provide abortion beyond 12 weeks. • The ambiguity in the guidelines wherein on one hand it describes the MMA schedule for second trimester abortions and on the other hand also specifies that MMA is not approved for use beyond 7 (or 9) weeks, is not just confusing, but may actually deter providers, especially in the public sector facilities, who are generally risk averse and would prefer to adhere to the guidelines. 	
<p>Impact: High.</p> <ul style="list-style-type: none"> • As there are no other safe and effective methods for MTP beyond 15 weeks’ gestation. • It would especially impact the public sector facilities as there is little clarity in the guidelines about whether or not MMA can be used for second trimester pregnancies. • It would also help in getting clarity regarding the use of MMA for gestations between 63 days and 12 weeks, which is presently a grey zone. 	<p>Feasibility High.</p>
<p>Additional discussions (if any):</p> <ul style="list-style-type: none"> • Some experts shared that “off-label” use of drugs is legal. However, the promotion of “off-label” use by pharmaceutical companies is illegal. • The experts said that IDF should explore the mechanism to seek the necessary approvals / change in recommendations for the use of the drugs at the level of the DCGI. <ul style="list-style-type: none"> - Some people were of the view that the government needs to approach the DCGI for the change. 	

- Others said that for such a change (in the indications for use of drugs) could not be initiated by the Ministry, but had to be led by the pharmaceutical industry / drug manufacturers.
- Given that the drugs are being used even now for second trimester abortions, there may not be sufficient increase in sales in order to “motivate” the pharmaceutical companies to approach the DCGI. In that case, it was suggested that FOGSI should ask the companies to approach DCGI.
- In addition to the benefits related to second trimester abortions, the experts felt that this would also help with research regarding the use of misoprostol for second trimester abortions, for which presently they need to seek special permissions from DCGI.

Gap 2.2.2: Nurses not permitted to provide second trimester abortions using medical methods.

Recommendation (original):	
LEGAL:	
<ul style="list-style-type: none"> - Expand the definition of an RMP to include nurses. - The law may differentiate between the various methods used for termination in the second trimester in terms of the cadres eligible to perform the same. While the use of surgical methods (see task 2.1 above) may be restricted to the doctors only, the provision of MMA in the second trimester may be expanded to include Nurses too in the eligible provider base. - The eligibility may be conditional (in line with the WHO task-shifting guidelines) to include those who are working in secondary or tertiary care facilities and therefore have access to surgical back-up in case the need arises. 	
Recommendation (revised, if any):	
None.	
Rationale:	
<ul style="list-style-type: none"> • There are hardly any nurses who are working independently, hence there is no need to bring about this change. 	
Impact:	Feasibility
<p>Low.</p> <p>Even if this change is brought about, this would not have any impact as there are hardly any places where nurses are working independently without the supervision of a doctor; hence this recommendation is not expected to increase access to and/or quality of abortion services.</p>	<p>Not discussed.</p>
Additional discussions (if any):	
None.	

Task 3: Recognizing and managing non-life threatening complications

Task 3.1: Initial management of non-life-threatening post-abortion infection

Gap 3.1.1: AYUSH doctors not permitted to provide initial management of post-abortion infection.

<p>Recommendation (original): POLICY: Addition of AYUSH providers (all except Yoga and Naturopathy) as another cadre in the Operational Guidelines and Provider’s Manual and defining tasks for them, including the provision of initial management for post-abortion infections, which should include provision of oral or parenteral antibiotics.</p>	
<p>Recommendation (revised, if any): None.</p>	
<p>Rationale:</p> <ul style="list-style-type: none"> • As the AYUSH doctors are already permitted to conduct deliveries and provide initial management of common obstetric complications, they can do this too. • The Nurses and ANMs are already permitted to do this. 	
<p>Impact: Medium.</p>	<p>Feasibility High. This would only require changes to the CAC Operational guidelines, which can be done at the level of the Ministry.</p>
<p>Additional discussions (if any):</p> <ul style="list-style-type: none"> • Like for SBA and other services, the AYUSH providers need to be trained / oriented on this issue too. 	

Task 3.2: Initial management of non-life-threatening post-abortion hemorrhage

Gap 3.2.1: **AYUSH doctors not permitted to provide initial management of post-abortion hemorrhage.**

Recommendation (original):	
POLICY: Addition of AYUSH providers (all except Yoga and Naturopathy) as another cadre in the Operational Guidelines and Provider's Manual and defining tasks for them, including the provision of initial management for post-abortion hemorrhage, which should include provision of IV fluids.	
Recommendation (revised, if any):	
None.	
Rationale:	
<ul style="list-style-type: none"> Same as under Gap 3.1.1 above 	
Impact:	Feasibility
Medium.	High. This would only require changes to the CAC Operational guidelines, which can be done at the level of the Ministry.
Additional discussions (if any):	
<ul style="list-style-type: none"> Like for SBA and other services, the AYUSH providers need to be trained / oriented on this issue too. 	

Task 4: Counselling and information provision

Task 4.1: Provision of general information on safe providers, laws, contraception options

Gap 4.1.1: Pharmacists and pharmacy workers not involved in provision of information on abortion services.

<p>Recommendation (original): POLICY: Inclusion of the pharmacists and pharmacy workers, as providers of information on abortion, as part of the Operational Guidelines and other policy documents on CAC.</p>	
<p>Recommendation (revised, if any): None.</p>	
<p>Rationale:</p> <ul style="list-style-type: none"> • There are huge numbers of pharmacists and pharmacy workers in the workforce. • They are often the first point of contact for women seeking abortion. • Despite being a Scheduled drug, i.e. to be dispensed on prescription only, the MMA drug kit is often provided as an OTC drug on demand. This is supported by the sales numbers for the kits, which is far higher than the abortions reported to the government as mandated under the MTP Act. Thus, with the expansion of MMA use, the role of the pharmacist for provision of correct information becomes even more important. 	
<p>Impact: High. Provision of information by this cadre would help refer woman to legal providers which would lead to scientific and supervised care of the women resulting in fewer complications.</p>	<p>Feasibility High. This would only require changes to the CAC Operational guidelines, which can be done at the level of the Ministry.</p>
<p>Additional discussions (if any): There was a significant difference in opinion of the experts on this issue. The counter arguments included:</p> <ul style="list-style-type: none"> • While pharmacists would be relatively easy to identify and orient, it would be difficult to do the same for pharmacy workers as: <ul style="list-style-type: none"> - This is an “undefined” mixed category of workers with varied qualifications; in some cases they may be barely literate. - This is a “floating” cadre, i.e. they keep on changing jobs frequently. - Given the above, listing them, especially those in the private sector would be an issue. - Given the probable huge numbers, orientation would be very time consuming and would need to be repeated multiple times. - Pharmacists running multiple shops under a single license may be loath to share details of these workers as often this cadre may be working / dispensing without supervision, which is not permitted under the law. • Reaching out to pharmacists working in the public sector facilities would be feasible; however it would not be so easy with those running their own pharmacies / chemist shops, i.e. private sector. And the latter are significantly more in numbers 	

Task 4.2: Pre- and post-abortion counselling**Gap 4.2.1: AYUSH doctors not involved in counselling on abortion care.**

Recommendation (original): POLICY: Inclusion of the AYUSH doctors (all except practitioners of Yoga and Naturopathy) as providers of pre- and post-counselling for abortion services in the various CAC documents including the Operational Guidelines as well as the Provider's Manual.	
Recommendation (revised, if any): None.	
Rationale: <ul style="list-style-type: none"> It is now being proposed that AYUSH doctors be included as one of the cadres permitted to provide MMA. Counselling is an integral part of provision of abortion services. So, if they would have to provide counselling as part of the services. 	
Impact: High. Because of the significant numbers of AYUSH providers. Also, there is data to show that women do approach these providers for abortion services.	Feasibility High. <ul style="list-style-type: none"> This would only require changes to the CAC Operational guidelines, which can be done at the level of the Ministry. Additionally there is low risk of any opposition for this element of CAC services from the allopathic providers.
Additional discussions (if any): <ul style="list-style-type: none"> The guidance should include AYUSH providers in both the public and the private sector. This is important because while in the public sector there is a chance that they are working under the supervision of an MBBS (allopathic) doctor, in the private sector they work independently. Also, there are more such providers in the private than in the public sector facilities. 	

Task 5: Post-abortion contraception provision

Task 5.1: Insertion and removal of IUCDs

Gap 5.1.1: Restrictions on AYUSH doctors, Nurses and ANMs for provision of post-abortion IUCD services.

<p>Recommendation (original): POLICY: Require clarification in the roles of ANMs, Nurses and AYUSH doctors regarding PAIUCD insertion and ensure that all policy documents including guidelines and training documents are in sync and provide the same message.</p> <p>The clarification should also specify the abortion trimesters after which these cadres are permitted to insert PAIUCD and ensure that they match the guidelines in the WHO MEC guidance.</p>	
<p>Recommendation (revised, if any): None.</p>	
<p>Rationale:</p> <ul style="list-style-type: none"> • These cadres are already permitted to insert IUCDs – both interval and PPIUCD following training Thus, PAIUCD is just an expansion of the bandwidth of services. 	
<p>Impact: Medium. While the change in guidelines may or may not impact delivery of these services in the public sector, it would open the gates for the nurses working in the private sector.</p>	<p>Feasibility High. As this would only require syncing the PAFP and CAC guidelines to the other FP related guidelines; this can be done at the level of the Ministry.</p>
<p>Additional discussions (if any): None.</p>	

Task 5.2: Insertion and removal of implants**Gap # 5.2.1 – Contraceptive hormonal implants not approved for use in India**

Recommendation (original): POLICY: Approval, by Government of India, for the use of implants in the country.	
Recommendation (revised, if any): LEGAL: Approval, by Government of India, for the use of implants in the country.	
Rationale: <ul style="list-style-type: none"> As it involves approval by the DCGI, this is a legal, and not a policy level change. It is important to expand the basket of contraceptive options in order to increase choice for the women and couples; this will increase contraceptive use and reduce unwanted pregnancies and the need for abortions. 	
Impact: High. Implants are long-acting reversible contraceptives. They have a low failure rate and will help in reducing unwanted pregnancies.	Feasibility High. The ICMR study on implants is over and the results are positive. The reports have been submitted to DCGI, and hence receiving approval should not be very difficult at this stage.
Additional discussions (if any): <ul style="list-style-type: none"> The process of approval needs to be routed through the manufacturers of hormonal implants. They need to apply to Central Drug Control Standard Organization (CDCSO) for licensing of the product and also submit pertinent evidence regarding its efficacy and safety as part of the application. 	

Recommendation (original): POLICY: Following approval, technical and operational guidelines will need to be drawn up for various cadres, which need to ensure that provisions on task allowance matches the WHO recommendations.	
Recommendation (revised, if any): None.	
Rationale: <ul style="list-style-type: none"> Linked and similar to the recommendation above. 	
Impact: Not discussed explicitly but linked to recommendation above.	Feasibility Not discussed explicitly, but linked to recommendation above.
Additional discussions (if any): <ul style="list-style-type: none"> The first version of the background note stated that as these cadres manage of obstetric complications, this was a rationale for permitting them to insert and remove implants. The expert group felt that management of obstetric complications and insertion of implants are not comparable skills, and hence should be removed from the rationale for this recommendation. 	

Task 5.3: Initiation and continuation of injectable contraceptives

Gap 5.3.1: ASHA, pharmacists and pharmacy workers not permitted to administer injectable contraceptives (following abortions).

Recommendation (original): POLICY: Inclusion of the ASHAs, pharmacists and pharmacy workers in the list of eligible providers for injectable contraceptives.	
Recommendation (revised, if any): None.	
Rationale: <ul style="list-style-type: none"> Skills for administering injections is not part of the training and/or scope of work of any of these three cadres, i.e. ASHAs, pharmacy workers and pharmacists. 	
Impact: Not applicable.	Feasibility Not applicable.
Additional discussions (if any): <ul style="list-style-type: none"> None. 	

Gap 5.3.2: Restrictions on AYUSH doctors, Nurses and ANMs for providing injectable contraceptives (following abortions).

Recommendation (original): POLICY: Remove the restriction in the Reference Manual for DMPA for AYUSH doctors (all except Yoga and Naturopathy), ANMs and Nurses on assessing the eligibility of clients for injectable contraceptives and prescribing and administering the same, including the first dose.	
Recommendation (revised, if any): None.	
Rationale: <ul style="list-style-type: none"> Assessing the woman for her eligibility to receive injectable contraceptives is a relatively easy skill to learn. 	
Impact: High. <ul style="list-style-type: none"> Will lead to doorstep delivery / increase access to injectable contraceptives. Ready access will increase demand. High demand will lead to a further reduction in prices due to economies of scale. 	Feasibility Currently, not feasible <ul style="list-style-type: none"> Injectable contraceptives like DMPA are listed under Schedule H of the Drugs and Cosmetics Act. This means that these are prescription-only drugs and can be prescribed by only MBBS (allopathic) doctors. Given the recent introduction of DMPA in the public sector basket of contraceptives, preparation of related guidelines and initiation of training of different cadres based on their currently decided roles, any further changes in the short-term to this new initiative will not be feasible.

Additional discussions (if any):

- The change in policy documents related to DMPA need to be accompanied by a change in the listing of the drug on the Drugs and Cosmetics Acts schedule.



PART C

Self-management of first trimester MMA


Self-management of the medical abortion process in the first trimester

This section was not part of the original background note, as the focus of the document was on task-shifting of CAC related services among health care providers. However, on the second day of the meeting, as the discussions on the other topics drew to a close, the group decided to look into the recommendations on self-management (by the woman) of the abortion process, and discuss the applicability of the same in the Indian context.

The following table, consolidates the mapping of the Indian scenario with the WHO recommendations for this context, and also shows the opinion of the experts regarding, if and how these recommendations may be implemented in India.

Task	WHO recommendation	Current Indian scenario	Expert group recommendation
Managing the entire process of medical abortion up to 84 days	No recommendation (insufficient evidence)	See below	No recommendation
Self-assessing eligibility for medical abortion		Initial assessment of gestational age and eligibility done by the health provider as part of the first visit (Day 1)	Not recommended. The woman will need to approach the health practitioner for care, and assessment of eligibility is part of that initial visit.
Managing the mifepristone and misoprostol medication without direct supervision of a health care provider	 ⁵⁸	According to the GOI Handbook on MMA - A minimum of three visits to the health provider are required for MMA - Visit # 1-Day 1: To assess eligibility and give dose of mifepristone.	There was a partial acceptance of the WHO recommendation - First visit is required to assess gestational age and eligibility. It is not expected to be an additional burden on the woman as she is expected to approach the health provider in any case for services (prescription). - The guidelines do not specify the site (home or facility) where mifepristone needs to be administered. So, while it can be assumed that the woman can take the dose at home, the experts felt that it would be best to make a change in the guidelines that explicitly state that the woman may take the dose of mifepristone at home subject to the treating physician's discretion.

⁵⁸ Where women have a source of accurate information and access to a health care provider should they need or want it at any stage of the process

<p>Self-assessing completeness of the abortion process using pregnancy tests and checklists.</p>	 <p>58, 59</p>	<p>However, it is possible that the mifepristone is not administered at the first visit, but later (in that case the day of the administration is counted as Day 1)</p> <ul style="list-style-type: none"> - Visit # 2-Day 3: To give dose of misoprostol. However, home administration of misoprostol is allowed on the provider's discretion. (This will reduce the number of visits to two. - Visit # 3-Day 15: To assess completeness of abortion 	<ul style="list-style-type: none"> - The guidelines already permit self-administration of misoprostol at home based on the provider's discretion. Hence no change required there. - The visit # 2 on Day 3, does not necessarily require a visit and can be done through other means of contact as convenient to the provider and the patient, such as through telecommunication. Hence, in the guidelines, the term "visit" should be changed to "contact" (with the health provider) for day 3. 	<p>The group did not agree with this recommendation of self-assessment by the woman for completeness of abortion and felt a visit to the health provider was important because:</p> <ul style="list-style-type: none"> - Follow-up by a health provider is essential to assess completeness of abortion - It is also important to get the data / information on the results of the MMA process - This visit also helps in counselling and acceptance of PAFP. In case the woman opts for PAIUCD, this visit can be used for insertion of the same.
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⁵⁹ Where both mifepristone and misoprostol are used.

Annex 1

List of Experts at the meeting

S.No.	Name	Organization
1	Dr. Amrita Kansal	World Health Organization, India
2	Mr. Anand Sinha	David and Lucile Packard Foundation
3	Dr. Anchita Patil	Technical Consultant
4	Dr. Bela Ganatra	World Health Organization, Geneva
5	Dr. B. K. Suvedi	Former Director, Department of Health Services, Government of Nepal
6	Dr. Dinesh Agarwal	IPE Global
7	Dr. G.N. Qazi	Hamdard Institute of Medical Sciences and Research
8	Dr. Himanshu Bhushan	National Health Systems Resource Centre
9	Dr. Jyotsna Suri	Vardhman Mahavir Medical College and Safdarjung Hospital
10	Dr. Manju Chhugani	Jamia Hamdard College of Nursing
11	Ms. Medha Gandhi	Ipas Development Foundation
12	Mr. Ram Bhat	Options and Solutions (Facilitator)
13	Ms. Ritu Raj	Ipas Development Foundation
14	Dr. Sangeeta Batra	Ipas Development Foundation
15	Dr. Sharad Iyengar	Action Research & Training for Health (ARTH)
16	Dr. S. K. Sharma	Former Advisor Ayurveda, Ministry of AYUSH
17	Ms. Sunita Beniwal	Safdarjung Hospital
18	Mr. Vinoj Manning	Ipas Development Foundation

Session Plan

Drafting Policy Recommendations

Role of Health-workers in Expanding Access to Safe Abortion Care and Post-abortion Contraception in India

Day 1: Monday, February 06, 2017

Venue: Bargad Hall III, Taj Gateway Resort, Damdama

10:00 onwards	Tea and registration
10:30	Welcome and objectives
10:45	Setting the context, meeting structure and introductions
11:00	Overview of the WHO guidance on health-workers role in providing safe abortion care and post abortion contraception
11:15	Task-shifting in Nepal: successes and challenges
11:45	Introduction to the background note with overview of specific tasks to be discussed by the groups
12:00	Group work Group 1: Management of abortion and post-abortion care in the first trimester Group 2: Counselling and information provision and Post-abortion contraception provision (two tasks)
1:00	Lunch
2:00	Group work continues
3:00	Tea/Coffee
3.30	Group 1 presentation on revisions to the mapping and recommendations and group consensus on recommendations
4:30	Group 2 presentation on revisions to the mapping and recommendations and group consensus on recommendations for both the tasks
5:30	Summary of day 1 and plan for day 2
7:15 pm	Dinner

Day 2: Monday, February 06, 2017

Venue: Bargad Hall, Taj Gateway Resort, Damdama

8:30	Plan for the day
8:45	Overview of specific tasks and sub-tasks to be discussed during the upcoming group work
9:00	Group work Group 1: Recognizing and managing non-life-threatening complications Group 2: Management of abortion and post-abortion care in the second trimester
11:45	Tea/ Coffee
12:00	Group 1 presentation on key recommendations by the group
12:30	Group 2 presentation on key recommendations by the group
1:00	Next steps
1:15 onwards	Lunch and departures



For further information, please contact IDF at idf@ipas.org
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